Senate

General Assembly

File No. 426

February Session, 2018

Substitute Senate Bill No. 16

Senate, April 12, 2018

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist. and SEN. SOMERS of the 18th Dist., Chairpersons of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS REGARDING PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 4-28f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2018*):

(a) There is created a Tobacco and Health Trust Fund which shall be a separate nonlapsing fund. The purpose of the trust fund shall be to create a continuing significant source of funds to (1) support and encourage development of programs to reduce tobacco abuse through prevention, education and cessation programs, (2) support and encourage development of programs to reduce substance abuse, and (3) develop and implement programs to meet the unmet physical and mental health needs in the state.

(b) The trust fund may accept transfers from the Tobacco Settlement Fund and may apply for and accept gifts, grants or donations from

public or private sources to enable the trust fund to carry out its objectives.

(c) The trust fund shall be administered by a board of trustees, except that the board shall suspend its operations from July 1, 2003, to June 30, 2005, inclusive. The board shall consist of seventeen trustees. The appointment of the initial trustees shall be as follows: (1) The Governor shall appoint four trustees, one of whom shall serve for a term of one year from July 1, 2000, two of whom shall serve for a term of two years from July 1, 2000, and one of whom shall serve for a term of three years from July 1, 2000; (2) the speaker of the House of Representatives and the president pro tempore of the Senate each shall appoint two trustees, one of whom shall serve for a term of two years from July 1, 2000, and one of whom shall serve for a term of three years from July 1, 2000; (3) the majority leader of the House of Representatives and the majority leader of the Senate each shall appoint two trustees, one of whom shall serve for a term of one year from July 1, 2000, and one of whom shall serve for a term of three years from July 1, 2000; (4) the minority leader of the House of Representatives and the minority leader of the Senate each shall appoint two trustees, one of whom shall serve for a term of one year from July 1, 2000, and one of whom shall serve for a term of two years from July 1, 2000; and (5) the Secretary of the Office of Policy and Management, or the secretary's designee, shall serve as an ex-officio voting member. Following the expiration of such initial terms, subsequent trustees shall serve for a term of three years. The period of suspension of the board's operations from July 1, 2003, to June 30, 2005, inclusive, shall not be included in the term of any trustee serving on July 1, 2003. The trustees shall serve without compensation except for reimbursement for necessary expenses incurred in performing their duties. The board of trustees shall establish rules of procedure for the conduct of its business which shall include, but not be limited to, criteria, processes and procedures to be used in selecting programs to receive money from the trust fund. The trust fund shall be within the Office of Policy and Management for administrative purposes only. The board of trustees shall, [meet not less than biannually, except

during the fiscal years ending June 30, 2004, and June 30, 2005, and,**]** not later than January first of each year, except **[**during the fiscal years ending June 30, 2004, and June 30, 2005**]** following a fiscal year in which the trust fund does not receive a deposit from the Tobacco Settlement Fund, shall submit a report of its activities and accomplishments to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, in accordance with section 11-4a.

(d) (1) During the period commencing July 1, 2000, and ending June 30, 2003, the board of trustees, by majority vote, may recommend authorization of disbursement from the trust fund for the purposes described in subsection (a) of this section and section 19a-6d, provided the board may not recommend authorization of disbursement of more than fifty per cent of net earnings from the principal of the trust fund for such purposes. For the fiscal year commencing July 1, 2005, and each fiscal year thereafter, the board may recommend authorization of the net earnings from the principal of the trust fund for such purposes. For the fiscal year ending June 30, 2009, and each fiscal year thereafter, the board may recommend authorization of disbursement for such purposes of (A) up to one-half of the annual disbursement from the Tobacco Settlement Fund to the Tobacco and Health Trust Fund from the previous fiscal year, pursuant to section 4-28e, up to a maximum of six million dollars per fiscal year, and (B) the net earnings from the principal of the trust fund from the previous fiscal year. For the fiscal year ending June 30, 2014, and each fiscal year thereafter, the board may recommend authorization of disbursement of up to the total unobligated balance remaining in the trust fund after disbursement in accordance with the provisions of the general statutes and relevant special and public acts for such purposes, not to exceed twelve million dollars per fiscal year. The board's recommendations shall give (i) priority to programs that address tobacco and substance abuse and serve minors, pregnant women and parents of young children, and (ii) consideration to the availability of private matching funds. Recommended disbursements from the trust fund shall be in addition

to any resources that would otherwise be appropriated by the state for such purposes and programs.

(2) Except during the fiscal years ending June 30, 2004, and June 30, 2005, the board of trustees shall submit such recommendations for the authorization of disbursement from the trust fund to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies. Not later than thirty days after receipt of such recommendations, said committees shall advise the board of their approval, modifications, if any, or rejection of the board's recommendations. If said joint standing committees do not concur, the speaker of the House of Representatives, the president pro tempore of the Senate, the majority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the House of Representatives and the minority leader of the Senate each shall appoint one member from each of said joint standing committees to serve as a committee on conference. The committee on conference shall submit its report to both committees, which shall vote to accept or reject the report. The report of the committee on conference may not be amended. If a joint standing committee rejects the report of the committee on conference, the board's recommendations shall be deemed approved. If the joint standing committees accept the report of the committee on conference, the joint standing committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the board of said joint standing committees' approval or modifications, if any, of the board's recommended disbursement. If said joint standing committees do not act within thirty days after receipt of the board's recommendations for the authorization of disbursement, such recommendations shall be deemed approved. Disbursement from the trust fund shall be in accordance with the board's recommendations as approved or modified by said joint standing committees.

(3) After such recommendations for the authorization of disbursement have been approved or modified pursuant to

subdivision (2) of this subsection, any modification in the amount of an authorized disbursement in excess of fifty thousand dollars or ten per cent of the authorized amount, whichever is less, shall be submitted to said joint standing committees and approved, modified or rejected in accordance with the procedure set forth in subdivision (2) of this subsection. Notification of all disbursements from the trust fund made pursuant to this section shall be sent to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, through the Office of Fiscal Analysis.

(4) The board of trustees shall, not later than February first of each year, except **[**during the fiscal years ending June 30, 2004, and June 30, 2005**]** following a fiscal year in which the trust fund does not receive a deposit from the Tobacco Settlement Fund, submit a report to the General Assembly, in accordance with the provisions of section 11-4a, that includes all disbursements and other expenditures from the trust fund and an evaluation of the performance and impact of each program receiving funds from the trust fund. Such report shall also include the criteria and application process used to select programs to receive such funds.

Sec. 2. Subsection (a) of section 19a-55 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2018*):

(a) The administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to every such infant in its care an HIV-related test, as defined in section 19a-581, a test for phenylketonuria and other metabolic diseases, hypothyroidism, galactosemia, sickle cell disease, maple syrup urine disease, homocystinuria, biotinidase deficiency, congenital adrenal hyperplasia, severe combined immunodeficiency disease, adrenoleukodystrophy and such other tests for inborn errors of metabolism as shall be prescribed by the Department of Public Health. The tests shall be administered as soon after birth as is medically

appropriate. If the mother has had an HIV-related test pursuant to section 19a-90 or 19a-593, the person responsible for testing under this section may omit an HIV-related test. The Commissioner of Public Health shall (1) administer the newborn screening program, (2) direct persons identified through the screening program to appropriate specialty centers for treatments, consistent with any applicable confidentiality requirements, and (3) set the fees to be charged to institutions to cover all expenses of the comprehensive screening program including testing, tracking and treatment. The fees to be charged pursuant to subdivision (3) of this subsection shall be set at a minimum of ninety-eight dollars. The Commissioner of Public Health shall publish a list of all the abnormal conditions for which the department screens newborns under the newborn screening program, which shall include screening for amino acid disorders, organic acid disorders and fatty acid oxidation disorders, including, but not limited to, long-chain 3-hydroxyacyl CoA dehydrogenase (L-CHAD), **[**and**]** medium-chain acyl-CoA dehydrogenase (MCAD) and, subject to the approval of the Secretary of the Office of Policy and Management, any other disorder included on the recommended uniform screening panel pursuant to 42 USC 300b-10, as amended from time to time.

Sec. 3. (*Effective July 1, 2018*) The amount of the payments made by the state to full-time municipal health departments, pursuant to section 19a-202 of the general statutes, and to health districts, pursuant to section 19a-245 of the general statutes, shall be reduced proportionately in the event that the total of such payments in a fiscal year exceeds the amount appropriated for the purposes of said sections with respect to such fiscal year.

Sec. 4. Subsection (a) of section 19a-490 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) "Institution" means a hospital, short-term hospital special hospice, hospice inpatient facility, residential care home, nursing home facility, home health care agency, homemaker-home health aide

agency, behavioral health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, outpatient clinic, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency; **[**, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems;**]** and a residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disability. "Institution" does not include any facility for the care and treatment of persons with mental illness or substance use disorder operated or maintained by any state agency, except Whiting Forensic Hospital;

Sec. 5. Subdivision (18) of subsection (b) of section 1-210 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(18) Records, the disclosure of which the Commissioner of Correction, or as it applies to Whiting Forensic **[**Division facilities of the Connecticut Valley**]** Hospital, the Commissioner of Mental Health and Addiction Services, has reasonable grounds to believe may result in a safety risk, including the risk of harm to any person or the risk of an escape from, or a disorder in, a correctional institution or facility under the supervision of the Department of Correction or Whiting Forensic **[**Division facilities**]** Hospital. Such records shall include, but are not limited to:

(A) Security manuals, including emergency plans contained or referred to in such security manuals;

(B) Engineering and architectural drawings of correctional institutions or facilities or Whiting Forensic **[**Division**]** Hospital facilities;

(C) Operational specifications of security systems utilized by the Department of Correction at any correctional institution or facility or Whiting Forensic **[**Division**]** Hospital facilities, except that a general description of any such security system and the cost and quality of such system may be disclosed;

(D) Training manuals prepared for correctional institutions and facilities or Whiting Forensic **[**Division**]** Hospital facilities that describe, in any manner, security procedures, emergency plans or security equipment;

(E) Internal security audits of correctional institutions and facilities or Whiting Forensic **[**Division**]** Hospital facilities;

(F) Minutes or recordings of staff meetings of the Department of Correction or Whiting Forensic **[**Division**]** Hospital facilities, or portions of such minutes or recordings, that contain or reveal information relating to security or other records otherwise exempt from disclosure under this subdivision;

(G) Logs or other documents that contain information on the movement or assignment of inmates or staff at correctional institutions or facilities; and

(H) Records that contain information on contacts between inmates, as defined in section 18-84, and law enforcement officers;

Sec. 6. Subsection (c) of section 1-210 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) Whenever a public agency receives a request from any person confined in a correctional institution or facility or a Whiting Forensic **[**Division**]** Hospital facility, for disclosure of any public record under the Freedom of Information Act, the public agency shall promptly notify the Commissioner of Correction or the Commissioner of Mental Health and Addiction Services in the case of a person confined in a Whiting Forensic **[**Division**]** Hospital facility of such request, in the

manner prescribed by the commissioner, before complying with the request as required by the Freedom of Information Act. If the commissioner believes the requested record is exempt from disclosure pursuant to subdivision (18) of subsection (b) of this section, the commissioner may withhold such record from such person when the record is delivered to the person's correctional institution or facility or Whiting Forensic **[**Division**]** Hospital facility.

Sec. 7. Section 5-145a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Any condition of impairment of health caused by hypertension or heart disease resulting in total or partial disability or death to a member of the security force or fire department of The University of Connecticut or the aeronautics operations of the Department of Transportation, or to a member of the Office of State Capitol Police or any person appointed under section 29-18 as a special policeman for the State Capitol building and grounds, the Legislative Office Building and parking garage and related structures and facilities, and other areas under the supervision and control of the Joint Committee on Legislative Management, or to state personnel engaged in guard or instructional duties in the Connecticut Correctional Institution, Somers, Connecticut Correctional Institution, Enfield-Medium, the Carl Robinson Correctional Institution, Enfield, John R. Manson Youth Institution, Cheshire, the York Correctional Institution, the Connecticut Correctional Center, Cheshire, or the community correctional centers, or to any employee of the Whiting Forensic **[**Division**]** Hospital with direct and substantial patient contact, or to any detective, chief inspector or inspector in the Division of Criminal Justice or chief detective, or to any state employee designated as a hazardous duty employee pursuant to an applicable collective bargaining agreement who successfully passed a physical examination on entry into such service, which examination failed to reveal any evidence of such condition, shall be presumed to have been suffered in the performance of his duty and shall be compensable in accordance with the provisions of chapter 568, except that for the first three months of

compensability the employee shall continue to receive the full salary which he was receiving at the time of injury in the manner provided by the provisions of section 5-142. Any such employee who began such service prior to June 28, 1985, and was not covered by the provisions of this section prior to said date shall not be required, for purposes of this section, to show proof that he successfully passed a physical examination on entry into such service.

Sec. 8. Section 5-173 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) A state policeman in the active service of the Division of State Police within the Department of Emergency Services and Public Protection, or any person who is engaged in guard or instructional duties at the Connecticut Correctional Institution, Somers, the Connecticut Correctional Institution, Enfield-Medium, the Carl Robinson Correctional Institution, Enfield, the John R. Manson Youth Institution, Cheshire, the York Correctional Institution, the Connecticut Correctional Center, Cheshire and the community correctional centers, or any person exempt from collective bargaining who is engaged in custodial or instructional duties within the Department of Correction, or any person who is an employee of the Whiting Forensic **[**Division**]** Hospital with direct and substantial patient contact, or any person who is employed as a correctional counselor, correctional counselor supervisor, parole officer or parole supervisor or in a comparable job classification by the Board of Pardons and Paroles, or any member of tier I who has been designated as a hazardous duty member pursuant to an applicable collective bargaining agreement, who has reached his forty-seventh birthday and completed at least twenty years of hazardous duty service for the state or service as a state policeman or as guard or instructor at said correctional institutions or correctional centers, or service in a custodial or instructional position within the Department of Correction which is exempt from collective bargaining, or as an employee of the Whiting Forensic **[**Division**]** Hospital or its predecessor institutions, or as a correctional counselor, correctional counselor supervisor, parole officer or parole supervisor or in a

comparable job classification as an employee of the Board of Pardons and Paroles, shall be retired on his own application or on the application of the Commissioner of Emergency Services and Public Protection or the Commissioner of Correction, as the case may be.

(b) On or after October 1, 1982, each such person shall receive a monthly retirement income equal to one-twelfth of (1) fifty per cent of his base salary, as defined in subsection (b) of section 5-162, for such twenty years of service, plus (2) two per cent of his base salary for each year, taken to completed months, of Connecticut state service in excess of twenty years, except that any such person who is both a member of the Division of State Police within the Department of Emergency Services and Public Protection and a member of part B shall receive a permanently reduced retirement income upon reaching the age of sixty-five or, if earlier, upon receipt of Social Security disability benefits or, for any such state policeman, upon receipt of benefits under subsection (d) of section 5-142. Any such state police member shall have his monthly retirement income reduced by an amount equal to one-twelfth of one per cent of four thousand eight hundred dollars multiplied by the number of years of state service, taken to completed months.

(c) Any such person who, while so employed, was granted military leave to enter the armed forces, as defined by section 27-103, and who, upon his discharge and within ninety days, returned to such service, shall be granted retirement credit for any period of service in time of war, as defined by said section, and for military service during a national emergency declared by the President of the United States on and after September 1, 1939, toward the required minimum of twenty **[**years**]** years' service; and any such person may be granted credit for any such war service prior to such employment upon payment of contributions and interest computed in accordance with subsection (b) of section 5-180, but such service shall not be counted toward the minimum service requirement of twenty years.

(d) Any such person who, after retiring from hazardous duty as

designated pursuant to a collective bargaining agreement or from the Division of State Police or the employ of the Connecticut Correctional Institution, Somers, the Connecticut Correctional Institution, Enfield-Medium, the Carl Robinson Correctional Institution, Enfield, the John R. Manson Youth Institution, Cheshire, the York Correctional Institution, the Connecticut Correctional Center, Cheshire or a community correctional center, the Whiting Forensic **[**Division**]** Hospital or the Board of Pardons and Paroles, as the case may be, is employed by any other state agency may elect to receive the retirement income to which he was entitled at the time of his retirement from such hazardous duty or as a state policeman or employee of the correctional institution or correctional center, forensic **[**division**]** hospital or Board of Pardons and Paroles when his employment in such other agency ceases, but he shall not, in that case, be entitled to any retirement income by reason of service in such other agency except as provided in subsection (g) of this section.

(e) Notwithstanding the provisions of subsection (a) of this section, any state policeman who serves as Commissioner or Deputy Commissioner of Emergency Services and Public Protection and whose position as commissioner or deputy commissioner is terminated, abolished or eliminated for any reason or who otherwise leaves such position and who has completed twenty years of service as a state policeman but who has not reached his forty-seventh birthday, shall be entitled to a retirement income, in accordance with subsection (b) of this section.

(f) A member who has completed twenty years of hazardous duty service under this section, but who leaves such service on or after October 1, 1982, but prior to reaching his forty-seventh birthday shall, upon his own application be entitled to the benefits provided in subsection (b) of this section at any time after reaching his forty-seventh birthday.

(g) On and after October 1, 1982, an employee who has met the twenty-year minimum service requirement and is thus eligible for

benefits under this section shall have any other Connecticut state employment recognized in calculating the amount of his benefits.

Sec. 9. Subsection (d) of section 5-192f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) "Hazardous duty member" means a member who is a state policeman in the active service of the Division of State Police within the Department of Emergency Services and Public Protection, who is engaged in guard or instructional duties at the Connecticut Correctional Institution, Somers, the Connecticut Correctional Institution, Enfield-Medium, the Carl Robinson Correctional Institution, Enfield, the John R. Manson Youth Institution, Cheshire, the York Correctional Institution, the Connecticut Correctional Center, Cheshire or the community correctional centers, who is an employee of the Whiting Forensic **[**Division**]** Hospital or its predecessor institutions with direct and substantial patient contact, who is a detective, chief inspector or inspector in the Division of Criminal Justice or chief detective, who is employed as a correctional counselor, correctional counselor supervisor, parole officer or parole supervisor or in a comparable job classification by the Board of Pardons and Paroles, or who has been designated as a hazardous duty member pursuant to the terms of a collective bargaining agreement.

Sec. 10. Subsection (b) of section 17a-450 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) For the purposes of chapter 48, the Department of Mental Health and Addiction Services shall be organized to promote comprehensive, client-based services in the areas of mental health treatment and substance abuse treatment and to ensure the programmatic integrity and clinical identity of services in each area. The department shall perform the functions of: Centralized administration, planning and program development; prevention and treatment programs and facilities, both inpatient and outpatient, for persons with psychiatric

disabilities or persons with substance use disorders, or both; community mental health centers and community or regional programs and facilities providing services for persons with psychiatric disabilities or persons with substance use disorders, or both; training and education; and research and evaluation of programs and facilities providing services for persons with psychiatric disabilities or persons with substance use disorders, or both. The department shall include, but not be limited to, the following divisions and facilities or their successor facilities: The office of the Commissioner of Mental Health and Addiction Services; Capitol Region Mental Health Center; Connecticut Valley Hospital, including the Addictions Division **[**, the Whiting Forensic Division**]** and the General Psychiatric Division of Connecticut Valley Hospital; the Whiting Forensic Hospital; the Connecticut Mental Health Center; Ribicoff Research Center; the Southwest Connecticut Mental Health System, including the Franklin S. DuBois Center and the Greater Bridgeport Community Mental Health Center; the Southeastern Mental Health Authority; River Valley Services; the Western Connecticut Mental Health Network; and any other state-operated facility for the treatment of persons with psychiatric disabilities or persons with substance use disorders, or both, but shall not include those portions of such facilities transferred to the Department of Children and Families for the purpose of consolidation of children's services.

Sec. 11. Subdivision (3) of subsection (c) of section 17a-450 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(3) Work with public or private agencies, organizations, facilities or individuals to ensure the operation of the programs set forth in accordance with sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, as amended by this act, inclusive, 17a-580 to 17a-603, inclusive, and 17a-615 to 17a-618, inclusive;

Sec. 12. Subsection (a) of section 17a-450a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Department of Mental Health and Addiction Services shall constitute a successor department to the Department of Mental Health. Whenever the words "Commissioner of Mental Health" are used or referred to in the following general statutes, the words "Commissioner of Mental Health and Addiction Services" shall be substituted in lieu thereof and whenever the words "Department of Mental Health" are used or referred to in the following general statutes, the words "Department of Mental Health and Addiction Services" shall be substituted in lieu thereof: 4-5, as amended by this act, 4-38c, 4-77a, 4a-12, 4a-16, 5-142, 8-206d, 10-19, 10-71, 10-76d, 17a-14, 17a-26, 17a-31, 17a-33, 17a-218, 17a-246, 17a-450, as amended by this act, 17a-451, 17a-453, 17a-454, 17a-455, 17a-456, 17a-457, 17a-458, as amended by this act, 17a-459, 17a-460, 17a-464, 17a-465, 17a-466, 17a-467, 17a-468, 17a-470, as amended by this act, 17a-471, 17a-472, as amended by this act, 17a-473, 17a-474, 17a-476, 17a-478, 17a-479, 17a-480, 17a-481, 17a-482, 17a-483, 17a-484, 17a-498, as amended by this act, 17a-499, as amended by this act, 17a-502, 17a-506, 17a-510, 17a-511, 17a-512, 17a-513, 17a-519, as amended by this act, 17a-528, 17a-560, as amended by this act, 17a-561, as amended by this act, 17a-562, as amended by this act, 17a-565, **[**17a-576,**]** as amended by this act, 17a-581, 17a-582, 17a-675, 17b-28, 17b-59a, as amended by this act, 17b-222, 17b-223, 17b-225, 17b-359, 17b-694, 19a-82, 19a-495, 19a-498, 19a-507a, 19a-507c, 19a-576, 19a-583, 20-14i, 20-14j, 21a-240, 21a-301, 27-122a, 31-222, 38a-514, 46a-28, 51-51o, 52-146h and 54-56d.

Sec. 13. Subsection (c) of section 17a-458 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) "State-operated facilities" means those hospitals or other facilities providing treatment for persons with psychiatric disabilities or for persons with substance use disorders, or both, which are operated in

whole or in part by the Department of Mental Health and Addiction Services. Such facilities include, but are not limited to, the Capitol Region Mental Health Center, the Connecticut Valley Hospital, including the Addictions Division **[**, the Whiting Forensic Division**]** and the General Psychiatric Division of Connecticut Valley Hospital, the Whiting Forensic Hospital, the Connecticut Mental Health Center, the Franklin S. DuBois Center, the Greater Bridgeport Community Mental Health Center and River Valley Services.

Sec. 14. Section 17a-470 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each state hospital, state-operated facility or the Whiting Forensic **[**Division of the Connecticut Valley**]** Hospital for the treatment of persons with psychiatric disabilities or persons with substance use disorders, or both, except the Connecticut Mental Health Center, may have an advisory board appointed by the superintendent or director of the facility for terms to be decided by such superintendent or director. In any case where the present number of members of an advisory board is less than the number of members designated by the superintendent or director of the facility, he shall appoint additional members to such board in accordance with this section in such manner that the terms of an approximately equal number of members shall expire in each odd-numbered year. The superintendent or director shall fill any vacancy that may occur for the unexpired portion of any term. No member may serve more than two successive terms plus the balance of any unexpired term to which he had been appointed. The superintendent or director of the facility shall be an ex-officio member of the advisory board. Each member of an advisory board of a state-operated facility within the Department of Mental Health and Addiction Services assigned a geographical territory shall be a resident of the assigned geographical territory. Members of said advisory boards shall receive no compensation for their services but shall be reimbursed for necessary expenses involved in the performance of their duties. At least one-third of such members shall be from a substance abuse subregional planning and action council established

pursuant to section 17a-671, and at least one-third shall be members of the catchment area councils, as provided in section 17a-483, for the catchment areas served by such facility, except that members serving as of October 1, 1977, shall serve out their terms.

Sec. 15. Section 17a-471a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Mental Health and Addiction Services, in consultation and coordination with the advisory council established under subsection (b) of this section, shall develop policies and set standards related to clients residing on the Connecticut Valley Hospital campus and to the discharge of such clients from the hospital into the adjacent community. **[**Any such policies and standards shall assure that no discharge of any client admitted to Whiting Forensic Division under commitment by the Superior Court or transfer from the Department of Correction shall take place without full compliance with sections 17a-511 to 17a-524, inclusive, 17a-566 to 17a-575, inclusive, 17a-580 to 17a-603, inclusive, and 54-56d.**]**

(b) There is established a Connecticut Valley Hospital Advisory Council that shall advise the Commissioner of Mental Health and Addiction Services on policies concerning, but not limited to, building use, security, clients residing on the campus and the discharge of clients from the **[**campuses**]** campus into the adjacent community. In addition, the advisory council shall periodically review the implementation of the policies and standards established by the commissioner in consultation with the advisory council. The council shall be composed of six members appointed by the mayor of Middletown, six members appointed by the Commissioner of Mental Health and Addiction Services and one member who shall serve as chairperson appointed by the Governor.

Sec. 16. Section 17a-472 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Except as otherwise provided, the Commissioner of Mental Health

and Addiction Services shall appoint and remove (1) the superintendents and directors of state-operated facilities and divisions constituting the Department of Mental Health and Addiction Services, and (2) the director of the Whiting Forensic **[**Division of Connecticut Valley**]** Hospital, who shall report to the **[**director of forensic services**]** commissioner and shall have as **[**his**]** such director's sole responsibility the administration of the Whiting Forensic **[**Division**]** Hospital. Each superintendent or director shall be a qualified person with experience in health, hospital or mental health administration.

Sec. 17. Section 17a-495 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For the purposes of sections 17a-75 to 17a-83, inclusive, and 17a-615 to 17a-618, inclusive, the following terms shall have the following meanings: "Business day" means Monday to Friday, inclusive, except when a legal holiday falls on any such day; "hospital for psychiatric disabilities" means any public or private hospital, retreat, institution, house or place in which any mentally ill person is received or detained as a patient, but shall not include any correctional institution of this state; "mentally ill person" means any person who has a mental or emotional condition which has substantial adverse effects on his or her ability to function and who requires care and treatment, and specifically excludes a person who is an alcohol-dependent person or a drug-dependent person, as defined in section 17a-680; "patient" means any person detained and taken care of as a mentally ill person; "keeper of a hospital for psychiatric disabilities" means any person, body of persons or corporation which has the immediate superintendence, management and control of a hospital for psychiatric disabilities and the patients therein; "support" includes all necessary food, clothing and medicine and all general expenses of maintaining state hospitals for persons with psychiatric disabilities; "indigent person" means any person who has an estate insufficient, in the judgment of the Court of Probate, to provide for his or her support and has no person or persons legally liable who are able to support him or her; "dangerous to himself or herself or others" means there is a substantial risk that

physical harm will be inflicted by an individual upon his or her own person or upon another person, and "gravely disabled" means that a person, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital treatment is necessary and available and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired by his psychiatric disabilities. "Respondent" means a person who is alleged to be mentally ill and for whom an application for commitment to a hospital for persons with psychiatric disabilities has been filed; "voluntary patient" means any patient sixteen years of age or older who applies in writing to and is admitted to a hospital for psychiatric disabilities as a mentally ill person or any patient under sixteen years of age whose parent or legal guardian applies in writing to such hospital for admission of such patient; "involuntary patient" means any patient hospitalized pursuant to an order of a judge of the Probate Court after an appropriate hearing or a patient hospitalized for emergency diagnosis, observation or treatment upon certification of a qualified physician.

(b) For the purposes of this section, sections 17a-450 to 17a-484, inclusive, as amended by this act, **[**17a-495**]** 71a-496 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, and 17a-560 to **[**17a-576**]** 17a-575, as amended by this act, inclusive, the following terms shall have the following meanings: "Business day" means Monday to Friday, inclusive, except when a legal holiday falls on any such day; "hospital for persons with psychiatric disabilities" means any public or private hospital, retreat, institution, house or place in which any person with psychiatric disabilities is received or detained as a patient, but shall not include any correctional institution of this state; "patient" means any person detained and taken care of as a person with psychiatric disabilities; "keeper of a hospital for persons with psychiatric disabilities" means any person, body of persons or corporation which has the immediate superintendence, management and control of a hospital for persons with psychiatric disabilities and

the patients therein; "support" includes all necessary food, clothing and medicine and all general expenses of maintaining state hospitals for persons with psychiatric disabilities; "indigent person" means any person who has an estate insufficient, in the judgment of the Court of Probate, to provide for his or her support and has no person or persons legally liable who are able to support him or her; "dangerous to himself or herself or others" means there is a substantial risk that physical harm will be inflicted by an individual upon his or her own person or upon another person; "gravely disabled" means that a person, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital treatment is necessary and available and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired by his psychiatric disabilities; "respondent" means a person who is alleged to have psychiatric disabilities and for whom an application for commitment to a hospital for persons with psychiatric disabilities has been filed; "voluntary patient" means any patient sixteen years of age or older who applies in writing to and is admitted to a hospital for persons with psychiatric disabilities as a person with psychiatric disabilities or any patient under sixteen years of age whose parent or legal guardian applies in writing to such hospital for admission of such patient; and "involuntary patient" means any patient hospitalized pursuant to an order of a judge of the Probate Court after an appropriate hearing or a patient hospitalized for emergency diagnosis, observation or treatment upon certification of a qualified physician.

(c) For the purposes of sections 17a-495 to 17a-528, inclusive, as amended by this act, "person with psychiatric disabilities" means any person who has a mental or emotional condition which has substantial adverse effects on his or her ability to function and who requires care and treatment, and specifically excludes a person who is an alcohol-dependent person or a drug-dependent person, as defined in section 17a-680.

(d) For the purposes of sections 17a-453 to 17a-454, inclusive, 17a-456, 17a-458 to 17a-464, inclusive, as amended by this act, 17a-466 to 17a-469, inclusive, 17a-471, 17a-474, 17a-476 to 17a-484, inclusive, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, as amended by this act, inclusive, and 17a-615 to 17a-618, inclusive, "person with psychiatric disabilities" means any person who has a mental or emotional condition which has substantial adverse effects on his or her ability to function and who requires care and treatment, and specifically includes a person who is an alcohol-dependent person or a drug-dependent person, as defined in section 17a-680.

Sec. 18. Section 17a-496 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Any keeper of a hospital for psychiatric disabilities who wilfully violates any of the provisions of this section, sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, **[**17a-495**]** as amended by this act, 17a-497 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, shall be fined not more than two hundred dollars or imprisoned not more than one year or both.

Sec. 19. Subsection (b) of section 17a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Upon the motion of any respondent or his or her counsel, or the probate judge having jurisdiction over such application, filed not later than three days prior to any hearing scheduled on such application, the Probate Court Administrator shall appoint a three-judge court from among the probate judges to hear such application. The judge of the Probate Court having jurisdiction over such application under the provisions of this section shall be a member, provided such judge may disqualify himself in which case all three members of such court shall be appointed by the Probate Court Administrator. Such three-judge court when convened shall have all the powers and duties set forth

under sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, and shall be subject to all of the provisions of law as if it were a single-judge court. No such respondent shall be involuntarily confined without the vote of at least two of the three judges convened hereunder. The judges of such court shall designate a chief judge from among their members. All records for any case before the three-judge court shall be maintained in the Probate Court having jurisdiction over the matter as if the three-judge court had not been appointed.

Sec. 20. Subsection (g) of section 17a-498 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(g) The hospital shall notify each patient at least annually that such patient has a right to a further hearing pursuant to this section. If the patient requests such hearing, it shall be held by the Probate Court for the district in which the hospital is located. Any such request shall be immediately filed with the appropriate court by the hospital. After such request is filed with the Probate Court, it shall proceed in the manner provided in subsections (a), (b), (c) and (f) of this section. In addition, the hospital shall furnish the Probate Court for the district in which the hospital is located on a monthly basis with a list of all patients confined in the hospital involuntarily without release for one year since the last annual review under this section of the patient's commitment or since the original commitment. The hospital shall include in such notification the type of review the patient last received. If the patient's last annual review had a hearing, the Probate Court shall, within fifteen business days thereafter, appoint an impartial physician who is a psychiatrist from the list provided by the Commissioner of Mental Health and Addiction Services as set forth in subsection (c) of this section and not connected with the hospital in which the patient is confined or related by blood or marriage to the original applicant or to the respondent, which physician shall see and

examine each such patient within fifteen business days after such physician's appointment and make a report forthwith to such court of the condition of the patient on forms provided by the Probate Court Administrator. If the Probate Court concludes that the confinement of any such patient should be reviewed by such court for possible release of the patient, the court, on its own motion, shall proceed in the manner provided in subsections (a), (b), (c) and (f) of this section, except that the examining physician shall be considered one of the physicians required by subsection (c) of this section. If the patient's last annual review did not result in a hearing, and in any event at least every two years, the Probate Court shall, within fifteen business days, proceed with a hearing in the manner provided in subsections (a), (b), (c) and (f) of this section. All costs and expenses, including Probate Court entry fees provided by statute, in conjunction with the annual psychiatric review and the judicial review under this subsection, except costs for physicians appointed pursuant to this subsection, shall be established by, and paid from funds appropriated to, the Judicial Department, except that if funds have not been included in the budget of the Judicial Department for such costs and expenses, such payment shall be made from the Probate Court Administration Fund. Compensation of any physician appointed to conduct the annual psychiatric review, to examine a patient for any hearing held as a result of such annual review or for any other biennial hearing required pursuant to sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, shall be paid by the state from funds appropriated to the Department of Mental Health and Addiction Services in accordance with rates established by the Department of Mental Health and Addiction Services.

Sec. 21. Section 17a-499 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

All proceedings of the Probate Court, upon application made under

the provisions of sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576] 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, shall be in writing and filed in such court, and, whenever a court passes an order for the admission of any person to any state hospital for psychiatric disabilities, the court shall record the order and give a certified copy of such order and of the reports of the physicians to the person by whom such person is to be taken to the hospital, as the warrant for such taking and commitment, and shall also forthwith transmit a like copy to the Commissioner of Mental Health and Addiction Services, and, in the case of a person in the custody of the Commissioner of Correction, to the Commissioner of Correction. Whenever a court passes an order for the commitment of any person to any hospital for psychiatric disabilities, it shall, within three business days, provide the Commissioner of Mental Health and Addiction Services with access to identifying information including, but not limited to, name, address, sex, date of birth and date of commitment on all commitments ordered on and after June 1, 1998. All commitment applications, orders of commitment and commitment papers issued by any court in committing persons with psychiatric disabilities to public or private hospitals for psychiatric disabilities shall be in accordance with a form prescribed by the Probate Court Administrator, which form shall be uniform throughout the state. State hospitals and other hospitals for persons with psychiatric disabilities shall, so far as they are able, upon reasonable request of any officer of a court having the power of commitment, send one or more trained attendants or nurses to attend any hearing concerning the commitment of any person with psychiatric disabilities and any such attendant or nurse, when present, shall be designated by the court as the authority to serve commitment process issued under the provisions of sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576] 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive.

Sec. 22. Subsection (a) of section 17a-500 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each court of probate shall keep a record of the cases relating to persons with psychiatric disabilities coming before it under sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, and the disposition of them. It shall also keep on file the original application and certificate of physicians required by said sections, or a microfilm duplicate of such records in accordance with regulations issued by the Probate Court Administrator. All records maintained in the courts of probate under the provisions of said sections shall be sealed and available only to the respondent or his or her counsel unless the Court of Probate, after hearing held with notice to the respondent, determines such records should be disclosed for cause shown.

Sec. 23. Section 17a-501 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Any person with psychiatric disabilities, the expense of whose support is paid by himself or by another person, may be committed to any institution for the care of persons with psychiatric disabilities designated by the person paying for such support; and any indigent person with psychiatric disabilities, not a pauper, committed under the provisions of sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, shall be committed to any state hospital for psychiatric disabilities which is equipped to receive him, at the discretion of the Court of Probate, upon consideration of a request made by the person applying for such commitment.

Sec. 24. Section 17a-504 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective from passage*):

Any person who wilfully and maliciously causes, or attempts to cause, or who conspires with any other person to cause, any person who does not have psychiatric disabilities to be committed to any hospital for psychiatric disabilities, and any person who wilfully certifies falsely to the psychiatric disabilities of any person in any certificate provided for in sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, and any person who, under the provisions of said sections relating to persons with psychiatric disabilities, wilfully reports falsely to any court or judge that any person has psychiatric disabilities, shall be guilty of a class D felony.

Sec. 25. Section 17a-505 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

When any female with psychiatric disabilities is escorted to a state hospital for persons with psychiatric disabilities by a male guard, attendant or other employee of a correctional or reformatory institution, or by a male law enforcement officer, under the provisions of sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, the person so escorting her shall be accompanied by an adult member of her family or at least one woman.

Sec. 26. Section 17a-517 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[If any**]** Any person in the custody of the Commissioner of Correction who is brought to a hospital pursuant to the provisions of sections 17a-499, as amended by this act, 17a-509, 17a-512 to **[**17a-517**]** 17a-516, inclusive, 17a-520, 17a-521, **[**and**]** as amended by this act, or

54-56d [is a desperate or dangerous individual, such person] shall be hospitalized in the Whiting Forensic [Division] Hospital. If the Whiting Forensic [Division] Hospital is unable to accommodate such transfer, then such person shall remain in the custody of the commissioner at a correctional institution, there confined under appropriate care and supervision. Under no circumstances shall an inmate with psychiatric disabilities requiring maximum security conditions be placed in a state hospital for persons with psychiatric disabilities which does not have the facilities and trained personnel to provide appropriate care and supervision for such individuals.

Sec. 27. Section 17a-519 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each officer or indifferent person making legal service of any order, notice, warrant or other paper under the provisions of sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576] 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, shall be entitled to the same compensation as is by law provided for like services in civil causes. Physicians, for examining a person alleged to have psychiatric disabilities and making a certificate as provided by said sections, shall be entitled to a reasonable compensation established by the Commissioner of Mental Health and Addiction Services. The fees of the courts of probate shall be such as are provided by law for similar services. The Superior Court, on an appeal, may tax costs at its discretion.

Sec. 28. Section 17a-521 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Except as otherwise provided in this section, the superintendent [or keeper] of any institution used wholly or in part for the care of persons with psychiatric disabilities or the director of the Whiting Forensic [Division] Hospital may, under such provisions or agreements as [he] the director deems advisable for psychiatric supervision, permit any

patient of the institution under [his] the director's charge temporarily to leave such institution, in charge of his guardian, relatives or friends, or by himself or herself. A person confined to a hospital for psychiatric disabilities under the provisions of section 17a-584 may leave the hospital temporarily as provided under the provisions of section 17a-587. In the case of committed persons, the original order of commitment shall remain in force and effect during absence from the institution either on authorized or unauthorized leave until such patient is officially discharged by the authorities of such institution or such order is superseded by a court of competent jurisdiction. In the case of a patient on authorized leave, if it appears to be for the best interest of the public or for the interest and benefit of such patient, [he] the patient may return or be returned by [his] the patient's guardian, relatives or friends or [he] the patient may be recalled by the authorities of such institution, at any time during such temporary absence and prior to [his] the patient's official discharge. With respect both to patients on authorized and unauthorized leave, state or local police shall, on the request of the authorities of any such institution, assist in the rehospitalization of any patient on temporary leave or of any other patient committed to such institution by a court of competent jurisdiction or any person who is a patient under the provisions of section 17a-502, if, in the opinion of such authorities, the patient's condition warrants such assistance. The expense, if any, of such recall or return shall, in the case of an indigent, be paid by those responsible for [his] the patient's support or, in the case of a pauper, by the state. Leave under this section shall not be available to any person who is under a term of imprisonment or who has not met the requirements of the condition of release set to provide reasonable assurance of such person's appearance in court.

Sec. 29. Section 17a-525 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Any person aggrieved by an order, denial or decree of a Probate Court under sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as

amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, including any relative or friend, on behalf of any person found to have psychiatric disabilities, shall have the right of appeal in accordance with sections 45a-186 to 45a-193, inclusive. On the trial of an appeal, the Superior Court may require the state's attorney or, in the state's attorney's absence, some other practicing attorney of the court to be present for the protection of the interests of the state and of the public.

Sec. 30. Subsection (a) of section 17a-528 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) When any person is found to have psychiatric disabilities, and is committed to a state hospital for psychiatric disabilities, upon proceedings had under sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, all fees and expenses incurred upon the probate commitment proceedings, payment of which is not otherwise provided for under said sections, shall be paid by the state within available appropriations from funds appropriated to the Department of Mental Health and Addiction Services in accordance with rates established by said department; and, if such person is found not to have psychiatric disabilities, such fees and expenses shall be paid by the applicant.

Sec. 31. Subsection (a) of section 17a-548 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any patient shall be permitted to wear his or her own clothes; to keep and use personal possessions including toilet articles; **[**except for patients hospitalized in Whiting Forensic Division;**]** to be present during any search of his or her personal possessions, except a patient hospitalized in the maximum security service of Whiting Forensic

Hospital; to have access to individual storage space for such possessions; and in such manner as determined by the facility to spend a reasonable sum of his or her own money for canteen expenses and small purchases. These rights shall be denied only if the superintendent, director **[**,**]** or his or her authorized representative determines that it is medically harmful to the patient to exercise such rights. An explanation of such denial shall be placed in the patient's permanent clinical record.

Sec. 32. Section 17a-560 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in sections 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, unless specifically provided otherwise, **[**"division",**]** "hospital" means the Whiting Forensic **[**Division**]** Hospital, including the diagnostic unit established under the provisions of section 17a-562, as amended by this act, or any other facility of the Department of Mental Health and Addiction Services which the commissioner may designate as appropriate. The words **[**"institute"**]** "hospital" or "diagnostic unit", as used in sections 17a-566, as amended by this act, 17a-567, as amended by this act, 17a-570, as amended by this act, and **[**17a-576**]** 17a-575, as amended by this act, when applied to children or youths under the age of eighteen, mean any facility of the Department of Children and Families designated by the Commissioner of Children and Families. "Board" means the advisory and review board appointed under the provisions of section 17a-565, as amended by this act. "Commissioner" means the Commissioner of Mental Health and Addiction Services or in the case of children, the Commissioner of Children and Families.

Sec. 33. Section 17a-561 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Whiting Forensic **[**Division of the Connecticut Valley**]** Hospital shall exist for the care and treatment of (1) patients with psychiatric disabilities, confined in facilities under the control of the Department of Mental Health and Addiction Services, including persons who

require care and treatment under maximum security conditions, (2) persons convicted of any offense enumerated in section 17a-566, as amended by this act, who, after examination by the staff of the diagnostic unit of the **[**division**]** hospital as herein provided, are determined to have psychiatric disabilities and be dangerous to themselves or others and to require custody, care and treatment at the **[**division and**]** hospital, (3) inmates in the custody of the Commissioner of Correction who are transferred in accordance with sections 17a-512 to 17a-517, inclusive, as amended by this act, and who require custody, care and treatment at the **[**division**]** hospital, and (4) persons committed to the hospital pursuant to section 17a-582 or 54-56d.

Sec. 34. Section 17a-562 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Whiting Forensic **[**Division of the Connecticut Valley**]** Hospital shall be within the general administrative control and supervision of the Department of Mental Health and Addiction Services. The director, with the approval of the commissioner and the board, shall establish such **[**subdivisions**]** divisions, which may be located geographically separate from the **[**division**]** hospital, as may be deemed proper for the administrative control and the efficient operation thereof, one of which **[**subdivisions**]** divisions shall be the diagnostic unit.

Sec. 35. Section 17a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The director of the Whiting Forensic **[**Division**]** Hospital shall quarterly make a report to the Board of Mental Health and Addiction Services on the affairs of the **[**division**]** hospital, including reports of reexaminations and recommendations.

Sec. 36. Section 17a-565 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There shall be an advisory board for the **[**division**]** Whiting Forensic Hospital, constituted as follows: The Commissioner of Mental

Health and Addiction Services, three physicians licensed to practice in this state, two of whom shall be psychiatrists, two attorneys of this state, at least one of whom shall be in active practice and have at least five years' experience in the trial of criminal cases, one licensed psychologist with experience in clinical psychology, one licensed clinical social worker, and one person actively engaged in business who shall have at least ten years' experience in business management. Annually, on October first, the Governor shall appoint a member or members to replace those whose terms expire for terms of five years each. The board shall elect a chairman and a secretary, who shall keep full and accurate minutes of its meetings and preserve the same. The board shall meet at the call of the chairman at least quarterly. Members of the board shall receive no compensation for their duties as such but shall be reimbursed for their actual expenses incurred in the course of their duties. Said board shall confer with the staff of the **[**division**]** hospital and give general consultative and advisory services on problems and matters relating to its work. On any matter relating to the work of the **[**division**]** hospital, the board may also confer with the warden or superintendent of the affected Connecticut correctional institution.

(b) The advisory board shall develop policies and set standards related to clients residing in Whiting Forensic Hospital. Such policies and standards shall ensure that no discharge of any client admitted to said hospital under commitment by the Superior Court or transfer from the Department of Correction shall take place without full compliance with sections 17a-511 to 17a-524, inclusive, 17a-566 to 17a-575, inclusive, as amended by this act, 17a-580 to 17a-603, inclusive, and 54-56d.

Sec. 37. Section 17a-566 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Except as provided in section 17a-574, as amended by this act, any court prior to sentencing a person convicted of an offense for which the penalty may be imprisonment in the Connecticut

Correctional Institution at Somers, or of a sex offense involving (1) physical force or violence, (2) disparity of age between an adult and a minor or (3) a sexual act of a compulsive or repetitive nature, may if it appears to the court that such person has psychiatric disabilities and is dangerous to himself or others, upon its own motion or upon request of any of the persons enumerated in subsection (b) of this section and a subsequent finding that such request is justified, order the commissioner to conduct an examination of the convicted defendant by qualified personnel of the **[**division**]** hospital. Upon completion of such examination the examiner shall report in writing to the court. Such report shall indicate whether the convicted defendant should be committed to the diagnostic unit of the **[**division**]** hospital for additional examination or should be sentenced in accordance with the conviction. Such examination shall be conducted and the report made to the court not later than fifteen days after the order for the examination. Such examination may be conducted at a correctional facility if the defendant is confined or it may be conducted on an outpatient basis at the **[**division**]** hospital or other appropriate location. If the report recommends additional examination at the diagnostic unit, the court may, after a hearing, order the convicted defendant committed to the diagnostic unit of the **[**division**]** hospital for a period not to exceed sixty days, except as provided in section 17a-567, as amended by this act, provided the hearing may be waived by the defendant. Such commitment shall not be effective until the director certifies to the court that space is available at the diagnostic unit. While confined in said diagnostic unit, the defendant shall be given a complete physical and psychiatric examination by the staff of the unit and may receive medication and treatment without his consent. The director shall have authority to procure all court records, institutional records and probation or other reports which provide information about the defendant.

(b) The request for such examination may be made by the state's attorney or assistant state's attorney who prosecuted the defendant for an offense specified in this section, or by the defendant or his attorney in his behalf. If the court orders such examination, a copy of the

examination order shall be served upon the defendant to be examined.

(c) Upon completion of the physical and psychiatric examination of the defendant, but not later than sixty days after admission to the diagnostic unit, a written report of the results thereof shall be filed in quadruplicate with the clerk of the court before which he was convicted, and such clerk shall cause copies to be delivered to the state's attorney, to counsel for the defendant and to the Court Support Services Division.

(d) Such report shall include the following: (1) A description of the nature of the examination; (2) a diagnosis of the mental condition of the defendant; (3) an opinion as to whether the diagnosis and prognosis demonstrate clearly that the defendant is actually dangerous to himself or others and requires custody, care and treatment at the **[**division**]** hospital; and (4) a recommendation as to whether the defendant should be sentenced in accordance with the conviction, sentenced in accordance with the conviction and confined in the **[**institute**]** hospital for custody, care and treatment, placed on probation by the court or placed on probation by the court with the requirement, as a condition to probation, that he receive outpatient psychiatric treatment.

Sec. 38. Section 17a-567 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) If the report recommends that the defendant be sentenced in accordance with the conviction, placed on probation by the court or placed on probation by the court with the requirement, as a condition of such probation, that he receive outpatient psychiatric treatment, the defendant shall be returned directly to the court for disposition. If the report recommends sentencing in accordance with the conviction and confinement in the **[**division**]** hospital for custody, care and treatment, then during the period between the submission of the report and the disposition of the defendant by the court such defendant shall remain at the **[**division**]** hospital and may receive such custody, care and treatment as is consistent with his medical needs.

(b) If the report recommends confinement at the **[**division**]** hospital for custody, care and treatment, the court shall set the matter for a hearing not later than fifteen days after receipt of the report. Any evidence, including the report ordered by the court, regarding the defendant's mental condition may be introduced at the hearing by either party. Any staff member of the diagnostic unit who participated in the examination of the defendant and who signed the report may testify as to the contents of the report. The defendant may waive the court hearing.

(c) If at such hearing the court finds the defendant is not in need of custody, care and treatment at the **[**division**]** hospital, it shall sentence **[**him**]** the defendant in accordance with the conviction or place **[**him**]** the defendant on probation. If the court finds that **[**such person**]** the defendant is in need of outpatient psychiatric treatment, it may place **[**him**]** the defendant on probation on condition that **[**he**]** the defendant receive such treatment. If the court finds **[**such person**]** the defendant to have psychiatric disabilities and to be dangerous to himself, herself or others and to require custody, care and treatment at the **[**division**]** hospital, it shall sentence **[**him**]** the defendant in accordance with the conviction and order confinement in the **[**division**]** hospital for custody, care and treatment provided no court may order such confinement if the report does not recommend confinement at the **[**division**]** hospital. The defendant shall not be subject to custody, care and treatment under sections 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, beyond the maximum period specified in the sentence.

Sec. 39. Section 17a-568 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Nothing in sections 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, shall affect proceedings under sections 17a-580 to 17a-602, inclusive, 17b-250 and 54-56d.

Sec. 40. Section 17a-569 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Not less than once every six months the staff of the [institute] hospital shall give a complete psychiatric examination to every patient confined in the [division] hospital. As used in this section and sections 17a-570 to 17a-573, inclusive, as amended by this act, the word "patient" means any person confined for custody, care and treatment under section 17a-567, as amended by this act. Such examination shall ascertain whether the patient has psychiatric disabilities and is in need of custody, care and treatment at the [division] hospital and, in making such determination, the staff shall assemble such information and follow such procedures as are used in initial examinations by the diagnostic unit to indicate the need for custody, care and treatment. The record of the examination shall include the information required in subdivisions (1), (2) and (3) of subsection (d) of section 17a-566, as amended by this act, and a recommendation for the future treatment of the patient examined. The record of the examination may include a recommendation for transfer of the patient or change in confinement status.

Sec. 41. Section 17a-570 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As soon as is practicable, the director of the Whiting Forensic [Division] Hospital shall act upon the examination reports of the director's staff. Upon review of each report and upon consideration of what is for the benefit of the patient and for the benefit of society, the director shall determine whether such patient: (1) Is to remain in the [division] hospital for further treatment, or (2) has sufficiently improved to warrant discharge from the [division] hospital, provided if such patient was sentenced and confined in the [division] hospital under section 17a-567, as amended by this act, such patient shall not be released except upon order of the court by which such patient was confined under said section, after notice to said court by the director. The director shall report each determination made under this subsection to the court by which the patient was confined in the [division] hospital.

(b) If a report submitted by the director to the court under subsection (a) of this section recommends that the patient be returned to the custody of the Commissioner of Correction, the court shall set the matter for a hearing not later than fifteen days after receipt of such report.

(c) The court, upon its own motion or at the request of the patient or the patient's attorney, may at any time hold a hearing to determine whether such patient should be discharged from the **[**division**]** hospital prior to the expiration of the maximum period of the patient's sentence. Prior to such hearing, the **[**division**]** hospital shall file a report with the court concerning the patient's mental condition. The court may appoint a physician specializing in psychiatry to examine the patient and report to the court. Such hearing shall be held at least once every five years. If the court determines that the patient should be discharged from the **[**division**]** hospital, the patient shall be returned to the custody of the Commissioner of Correction.

Sec. 42. Section 17a-572 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

All certificates, applications, records and reports made for the purpose of sections 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, and directly or indirectly identifying a person subject to it shall be kept confidential and shall not be disclosed by any person except so far (1) as the individual identified or his legal guardian, if any, or, if he is a minor, his parent or legal guardian, consents or (2) as disclosure may be necessary to carry out any of the provisions of said sections or (3) as a court may direct upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make such disclosure would be contrary to the public interest.

Sec. 43. Section 17a-573 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Within two months prior to the expiration of the maximum term of

confinement authorized for any patient under section 17a-567, as amended by this act, the director of the **[**division**]** hospital may, upon the recommendation of the board, initiate proceedings under section 17a-497 or 17a-520, as amended by this act, for the commitment or further commitment, as the case may be, of the patient.

Sec. 44. Section 17a-574 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Nothing in sections 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, shall be construed to extend to or affect any case in the Superior Court involving a juvenile matter, or to any person arrested for an offense which is not punishable by imprisonment for more than one year or by a fine of not more than one thousand dollars or both or except as provided in section 46b-127.

Sec. 45. Section 17a-575 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Nothing in sections 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, shall be construed to limit or suspend the writ of habeas corpus.

Sec. 46. Subsection (d) of section 45a-656 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) The conservator of the person shall not have the power or authority to cause the respondent to be committed to any institution for the treatment of the mentally ill except under the provisions of sections 17a-75 to 17a-83, inclusive, 17a-456 to 17a-484, inclusive, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, 17a-615 to 17a-618, inclusive, and 17a-621 to 17a-664, inclusive, and chapter 359.

Sec. 47. Subsection (d) of section 45a-656 of the 2018 supplement to the general statutes, as amended by section 4 of public act 17-7, is

repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(d) The conservator of the person shall not have the power or authority to cause the respondent to be committed to any institution for the treatment of the mentally ill except under the provisions of sections 17a-75 to 17a-83, inclusive, 17a-456 to 17a-484, inclusive, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, 17a-615 to 17a-618, inclusive, and 17a-621 to 17a-664, inclusive, and chapter 359.

Sec. 48. Subsection (e) of section 45a-677 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) A plenary guardian or limited guardian shall not have the power or authority: (1) To cause the protected person to be admitted to any institution for treatment of the mentally ill, except in accordance with the provisions of sections 17a-75 to 17a-83, inclusive, 17a-456 to 17a-484, inclusive, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to **[**17a-576**]** 17a-575, inclusive, as amended by this act, 17a-615 to 17a-618, inclusive, and 17a-621 to 17a-664, inclusive, and chapter 420b; (2) to cause the protected person to be admitted to any training school or other facility provided for the care and training of persons with intellectual disability if there is a conflict concerning such admission between the guardian and the protected person or next of kin, except in accordance with the provisions of sections 17a-274 and 17a-275; (3) to consent on behalf of the protected person to a sterilization, except in accordance with the provisions of sections 45a-690 to 45a-700, inclusive; (4) to consent on behalf of the protected person to psychosurgery, except in accordance with the provisions of section 17a-543; (5) to consent on behalf of the protected person to the termination of the protected person's parental rights, except in accordance with the provisions of sections 45a-706 to 45a-709, inclusive, 45a-715 to 45a-718, inclusive, 45a-724 to 45a-737, inclusive,

and 45a-743 to 45a-757, inclusive; (6) to consent on behalf of the protected person to the performance of any experimental biomedical or behavioral medical procedure or participation in any biomedical or behavioral experiment, unless it (A) is intended to preserve the life or prevent serious impairment of the physical health of the protected person, (B) is intended to assist the protected person to regain the protected person's abilities and has been approved for the protected person by the court, or (C) has been (i) approved by a recognized institutional review board, as defined by 45 CFR 46, 21 CFR 50 and 21 CFR 56, as amended from time to time, which is not a part of the Department of Developmental Services, (ii) endorsed or supported by the Department of Developmental Services, and (iii) approved for the protected person by such protected person's primary care physician; (7) to admit the protected person to any residential facility operated by an organization by whom such guardian is employed, except in accordance with the provisions of section 17a-274; (8) to prohibit the marriage or divorce of the protected person; and (9) to consent on behalf of the protected person to an abortion or removal of a body organ, except in accordance with applicable statutory procedures when necessary to preserve the life or prevent serious impairment of the physical or mental health of the protected person.

Sec. 49. Section 18-101f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

A personnel or medical file or similar file concerning a current or former employee of the Division of Public Defender Services, Department of Correction or the Department of Mental Health and Addiction Services, including, but not limited to, a record of a security investigation of such employee by the department or division or an investigation by the department or division of a discrimination complaint by or against such employee, shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200, to any individual committed to the custody or supervision of the Commissioner of Correction or confined in a facility of the Whiting Forensic **[**Division of the Connecticut Valley**]** Hospital. For the

purposes of this section, an "employee of the Department of Correction" includes a member or employee of the Board of Pardons and Paroles within the Department of Correction.

Sec. 50. Subsection (a) of section 46a-152 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No provider or assistant may use involuntary physical restraint on a person at risk except (1) as an emergency intervention to prevent immediate or imminent injury to the person at risk or to others, provided the restraint is not used for discipline or convenience and is not used as a substitute for a less restrictive alternative, (2) as necessary and appropriate, as determined on an individual basis by the person's treatment team and consistent with sections 17a-540 to 17a-550, inclusive, for the transportation of a person under the jurisdiction of the Whiting Forensic **[**Division**]** Hospital of the Department of Mental Health and Addiction Services.

Sec. 51. Subsection (a) of section 12-19a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Until the fiscal year commencing July 1, 2016, on or before January first, annually, the Secretary of the Office of Policy and Management shall determine the amount due, as a state grant in lieu of taxes, to each town in this state wherein state-owned real property, reservation land held in trust by the state for an Indian tribe, a municipally owned airport, or any airport owned by the Connecticut Airport Authority, other than Bradley International Airport, except that which was acquired and used for highways and bridges, but not excepting property acquired and used for highway administration or maintenance purposes, is located. The grant payable to any town under the provisions of this section in the state fiscal year commencing July 1, 1999, and each fiscal year thereafter, shall be equal to the total of (1) (A) one hundred per cent of the property taxes which would have been paid with respect to any facility designated by the Commissioner

of Correction, on or before August first of each year, to be a correctional facility administered under the auspices of the Department of Correction or a juvenile detention center under direction of the Department of Children and Families that was used for incarcerative purposes during the preceding fiscal year. If a list containing the name and location of such designated facilities and information concerning their use for purposes of incarceration during the preceding fiscal year is not available from the Secretary of the State on the first day of August of any year, said commissioner shall, on said first day of August, certify to the Secretary of the Office of Policy and Management a list containing such information, (B) one hundred per cent of the property taxes which would have been paid with respect to that portion of the John Dempsey Hospital located at The University of Connecticut Health Center in Farmington that is used as a permanent medical ward for prisoners under the custody of the Department of Correction. Nothing in this section shall be construed as designating any portion of The University of Connecticut Health Center John Dempsey Hospital as a correctional facility, and (C) in the state fiscal year commencing July 1, 2001, and each fiscal year thereafter, one hundred per cent of the property taxes which would have been paid on any land designated within the 1983 Settlement boundary and taken into trust by the federal government for the Mashantucket Pequot Tribal Nation on or after June 8, 1999, (2) subject to the provisions of subsection (c) of this section, sixty-five per cent of the property taxes which would have been paid with respect to the buildings and grounds comprising Connecticut Valley Hospital and Whiting Forensic Hospital in Middletown. Such grant shall commence with the fiscal year beginning July 1, 2000, and continuing each year thereafter, (3) notwithstanding the provisions of subsections (b) and (c) of this section, with respect to any town in which more than fifty per cent of the property is state-owned real property, one hundred per cent of the property taxes which would have been paid with respect to such state-owned property. Such grant shall commence with the fiscal year beginning July 1, 1997, and continuing each year thereafter, (4) subject to the provisions of subsection (c) of this section, forty-five per cent of

the property taxes which would have been paid with respect to all other state-owned real property, (5) forty-five per cent of the property taxes which would have been paid with respect to all municipally owned airports or any airport owned by the Connecticut Airport Authority, other than Bradley International Airport, except for the exemption applicable to such property, on the assessment list in such town for the assessment date two years prior to the commencement of the state fiscal year in which such grant is payable. The grant provided pursuant to this section for any municipally owned airport or any airport owned by the Connecticut Airport Authority, other than Bradley International Airport, shall be paid to any municipality in which the airport is located, except that the grant applicable to Sikorsky Airport shall be paid half to the town of Stratford and half to the city of Bridgeport, and (6) forty-five per cent of the property taxes which would have been paid with respect to any land designated within the 1983 Settlement boundary and taken into trust by the federal government for the Mashantucket Pequot Tribal Nation prior to June 8, 1999, or taken into trust by the federal government for the Mohegan Tribe of Indians of Connecticut, provided (A) the real property subject to this subdivision shall be the land only, and shall not include the assessed value of any structures, buildings or other improvements on such land, and (B) said forty-five per cent grant shall be phased in as follows: (i) In the fiscal year commencing July 1, 2012, an amount equal to ten per cent of said forty-five per cent grant, (ii) in the fiscal year commencing July 1, 2013, thirty-five per cent of said forty-five per cent grant, (iii) in the fiscal year commencing July 1, 2014, sixty per cent of said forty-five per cent grant, (iv) in the fiscal year commencing July 1, 2015, eighty-five per cent of said forty-five per cent grant, and (v) in the fiscal year commencing July 1, 2016, one hundred per cent of said forty-five per cent grant.

Sec. 52. Subparagraph (D) of subdivision (1) of subsection (b) of section 12-18b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(D) Subject to the provisions of subsection (c) of section 12-19a,

sixty-five per cent of the property taxes that would have been paid with respect to the buildings and grounds comprising Connecticut Valley Hospital and Whiting Forensic Hospital in Middletown;

Sec. 53. (NEW) (*Effective October 1, 2018*) (a) As used in this section and section 54 of this act:

(1) "Abuse" means the wilful infliction of physical pain, injury or mental anguish, or the wilful deprivation by a caregiver of services which are necessary to maintain the physical and mental health of a patient;

(2) "Behavioral health facility" means any facility operated by the Department of Mental Health and Addiction Services that provides mental health or substance use disorder services to persons eighteen years of age or older;

(3) "Patient" means any person receiving services from a behavioral health facility;

(4) "Legal representative" means a court-appointed fiduciary, including a guardian or conservator, or a person with power of attorney authorized to act on a patient's behalf; and

(5) "Mandatory reporter" means (A) any person in a behavioral health facility paid to provide direct care for a patient of such facility, and (B) any employee, contractor or consultant of such facility who is a licensed healthcare provider.

(b) Any mandatory reporter, who, in the ordinary course of such person's employment, has reasonable cause to suspect or believe that any patient (1) has been abused, (2) is in a condition that is the result of abuse, or (3) has had an injury that is at variance with the history given of such injury, shall, not later than seventy-two hours after such suspicion or belief arose, report such information or cause a report to be made in any reasonable manner to the Commissioner of Mental Health and Addiction Services or to the person or persons designated by the commissioner to receive such reports. Any behavioral health

facility providing direct care for patients shall provide mandatory training on detecting potential abuse of patients to mandatory reporters and inform such individuals of their obligations under this section.

(c) Any mandatory reporter who fails to make a report under subsection (b) of this section or fails to make such report within the prescribed time period set forth in said subsection shall be fined not more than five hundred dollars, except if such person intentionally fails to make such report within the prescribed time period, such person shall be guilty of (1) a class C misdemeanor for the first violation, and (2) a class A misdemeanor for any subsequent violation.

(d) A report made under subsection (b) of this section shall contain the name and address of the behavioral health facility, the name of the patient, information regarding the nature and extent of the abuse and any other information the mandatory reporter believes may be helpful in an investigation of the case and for the protection of the patient.

(e) Any other person having reasonable cause to believe that a patient is being or has been abused shall report such information in accordance with subsection (b) of this section in any reasonable manner to the Commissioner of Mental Health and Addiction Services, or to the person or persons designated by the commissioner to receive such reports, who shall inform the patient or such patient's legal representative of the services of the nonprofit entity designated by the Governor in accordance with section 46a-10b of the general statutes to serve as the Connecticut protection and advocacy system.

(f) A report filed under this section shall not be deemed a public record, and shall not be subject to the provisions of section 1-210 of the general statutes, as amended by this act. Information derived from such report for which reasonable grounds are determined to exist after investigation, including the identity of the behavioral health facility, the number of complaints received, the number of complaints substantiated and the types of complaints, may be disclosed by the Commissioner of Mental Health and Addiction Services, except in no

case shall the name of the patient be revealed, unless such person specifically requests such disclosure or unless a judicial proceeding results from such report. Notwithstanding the provisions of this section, not later than twenty-four hours or as soon as possible after receiving a report under this section, the commissioner or the commissioner's designee shall notify such person's legal representative, if any. Such notification shall not be required when the legal representative is suspected of perpetrating the abuse that is the subject of the report. The commissioner shall obtain the contact information for such legal representative from the behavioral health facility.

(g) (1) Subject to subdivision (2) of this subsection, any person who makes a report under this section or who testifies in any administrative or judicial proceeding arising from the report shall be immune from any civil or criminal liability with regard to such report or testimony, except liability for perjury in the context of making such report.

(2) Any person who makes a report under this section is guilty of making a fraudulent or malicious report or providing false testimony when such person (A) wilfully makes a fraudulent or malicious report, (B) conspires with another person to make or cause to be made such fraudulent or malicious report, or (C) wilfully testifies falsely in any administrative or judicial proceeding arising from such report regarding the abuse of a patient. Making a fraudulent or malicious report or providing false testimony under this section is a class A misdemeanor.

(h) Any person who is discharged or in any manner discriminated or retaliated against for making, in good faith, a report under this section shall be entitled to all remedies available under law.

Sec. 54. (NEW) (*Effective October 1, 2018*) (a) The Commissioner of Mental Health and Addiction Services, upon receiving a report under section 53 of this act that a patient is being or has been abused, shall investigate the report to determine the condition of the patient and what action and services, if any, are required. The investigation shall

include (1) an in-person visit to the named patient, (2) consultation with those individuals having knowledge of the facts surrounding the particular report, and (3) an interview with the patient, unless the patient refuses to consent to such interview. Upon completion of the investigation, the commissioner shall prepare written findings that shall include recommended actions. Not later than forty-five days after completion of the investigation, the commissioner shall disclose, in general terms, the result of the investigation to the person or persons who reported the suspected abuse, provided: (A) The person who made such report is legally mandated to make such report, (B) the information is not otherwise privileged or confidential under state or federal law, (C) the names of the witnesses or other persons interviewed are kept confidential, and (D) the names of the person or persons suspected to be responsible for the abuse are not disclosed unless such person or persons have been arrested as a result of the investigation.

(b) The Department of Mental Health and Addiction Services shall maintain a state-wide registry of the number of reports received under this section, the allegations contained in such reports and the outcomes of the investigations resulting from such reports.

(c) The patient's file, including, but not limited to, the original report and the investigation report shall not be deemed a public record or subject to the provisions of section 1-210 of the general statutes, as amended by this act. The commissioner may disclose such file, in whole or in part, to an individual, agency, corporation or organization only with the written authorization of the patient, the patient's legal representative or as otherwise authorized under this section.

(d) Notwithstanding the provisions of subsection (c) of this section, the commissioner shall not disclose the name of a person who reported suspected abuse, except with such person's written permission or to a law enforcement official pursuant to a court order that specifically requires such disclosure.

(e) The patient or such patient's legal representative or attorney

shall have the right of access to records made, maintained or kept on file by the department, in accordance with all applicable state and federal law, when such records pertain to or contain information or material concerning the patient, including, but not limited to, records concerning investigations, reports or medical, psychological or psychiatric examinations of the patient, except: (1) If protected health information was obtained by the department from someone other than a health care provider under the promise of confidentiality and the access requested would, with reasonable likelihood, reveal the source of the information; (2) information identifying the individual who reported the abuse of the person shall not be released unless, upon application made to the Superior Court by the patient or such patient's legal representative or attorney and served on the Commissioner of Mental Health and Addiction Services, a judge determines, after in camera inspection of relevant records and a hearing, that there is reasonable cause to believe the individual knowingly made a false report or that other interests of justice require such release; (3) if it is determined by a licensed health care provider that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person; (4) if the protected health information makes reference to another person, other than a health care provider, and the access requested would reveal protected health information about such other person; or (5) the request for access is made by the patient's legal representative, and a licensed health care provider has determined, in the exercise of professional judgment, that the provision of access to such legal representative is reasonably likely to cause harm to the patient or another person.

Sec. 55. Section 19a-754a of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) There is established an Office of Health Strategy, which shall be within the Department of Public Health for administrative purposes only. The department head of said office shall be the executive director of the Office of Health Strategy, who shall be appointed by the

Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, as amended by this act, with the powers and duties therein prescribed.

(b) [On or before July 1, 2018, the] The Office of Health Strategy shall be responsible for the following:

(1) Developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy;

(2) Promoting effective health planning and the provision of quality health care in the state in a manner that ensures access for all state residents to cost-effective health care services, avoids the duplication of such services and improves the availability and financial stability of such services throughout the state;

[(2)] (3) Directing and overseeing [(A) the all-payers claims database program established pursuant to section 19a-755a, and (B)] the State Innovation Model Initiative and related successor initiatives;

[(3)] (4) (A) Coordinating the state's health information technology initiatives, (B) seeking funding for and overseeing the planning, implementation and development of policies and procedures for the administration of the all-payer claims database program established under section 19a-775a, as amended by this act, (C) establishing and maintaining a consumer health information Internet web site under 19a-755b, as amended by this act, and (D) designating an unclassified individual from the office to perform the duties of a health information technology officer as set forth in sections 17b-59f, as amended by this act, and 17b-59g, as amended by this act;

[(4)] (5) Directing and overseeing the [Office of Health Care Access] Health Systems Planning Unit established under section 19a-612, as amended by this act, and all of its duties and responsibilities as set forth in chapter 368z; and

[(5)] (6) Convening forums and meetings with state government and

external stakeholders, including, but not limited to, the Connecticut Health Insurance Exchange, to discuss health care issues designed to develop effective health care cost and quality strategies.

(c) The Office of Health Strategy shall constitute a successor, in accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the functions, powers and duties of the following:

(1) The Connecticut Health Insurance Exchange, established pursuant to section 38a-1081, relating to the administration of the all-payer claims database pursuant to section 19a-755a, as amended by this act; and

(2) The Office of the Lieutenant Governor, relating to the (A) development of a chronic disease plan pursuant to section 19a-6q, as amended by this act, (B) housing, chairing and staffing of the Health Care Cabinet pursuant to section 19a-725, as amended by this act, and (C) (i) appointment of the health information technology officer, **[**pursuant to section 19a-755,**]** and (ii) oversight of the duties of such health information technology officer as set forth in sections **[**17b-59, 17b-59a and**]** 17b-59f, as amended by this act, and 17b-59g, as amended by this act.

(d) Any order or regulation of the entities listed in subdivisions (1) and (2) of subsection (c) of this section that is in force on July 1, 2018, shall continue in force and effect as an order or regulation until amended, repealed or superseded pursuant to law.

Sec. 56. Section 4-5 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

As used in sections 4-6, 4-7 and 4-8, the term "department head" means Secretary of the Office of Policy and Management, Commissioner of Administrative Services, Commissioner of Revenue Services, Banking Commissioner, Commissioner of Children and Families, Commissioner of Consumer Protection, Commissioner of

Correction, Commissioner of Economic and Community Development, State Board of Education, Commissioner of Emergency Services and Public Protection, Commissioner of Energy and Environmental Protection, Commissioner of Agriculture, Commissioner of Public Health, Insurance Commissioner, Labor Commissioner, Commissioner of Mental Health and Addiction Services, Commissioner of Social Services, Commissioner of Developmental Services, Commissioner of Motor Vehicles, Commissioner of Transportation, Commissioner of Veterans Affairs, Commissioner of Housing, Commissioner of Rehabilitation Services, the Commissioner of Early Childhood, **[**and**]** the executive director of the Office of Military Affairs and the executive director of the Office of Health Strategy. As used in sections 4-6 and 4-7, "department head" also means the Commissioner of Education.

Sec. 57. Section 4-5 of the 2018 supplement to the general statutes, as amended by section 6 of public act 17-237 and section 279 of public act 17-2 of the June special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

As used in sections 4-6, 4-7 and 4-8, the term "department head" means Secretary of the Office of Policy and Management, Commissioner of Administrative Services, Commissioner of Revenue Services, Banking Commissioner, Commissioner of Children and Families, Commissioner of Consumer Protection, Commissioner of Correction, Commissioner of Economic and Community Development, State Board of Education, Commissioner of Emergency Services and Public Protection, Commissioner of Energy and Environmental Protection, Commissioner of Agriculture, Commissioner of Public Health, Insurance Commissioner, Labor Commissioner, Commissioner of Mental Health and Addiction Services, Commissioner of Social Services, Commissioner of Developmental Services, Commissioner of Motor Vehicles, Commissioner of Transportation, Commissioner of Veterans Affairs, Commissioner of Housing, Commissioner of Rehabilitation Services, the Commissioner of Early Childhood, the executive director of the Office of Military Affairs, **[**and**]** the executive

director of the Technical Education and Career System and the executive director of the Office of Health Strategy. As used in sections 4-6 and 4-7, "department head" also means the Commissioner of Education.

Sec. 58. Section 19a-755a of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) As used in this section:

(1) "All-payer claims database" means a database that receives and stores data from a reporting entity relating to medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files.

(2) (A) "Reporting entity" means:

(i) An insurer, as described in section 38a-1, licensed to do health insurance business in this state;

(ii) A health care center, as defined in section 38a-175;

(iii) An insurer or health care center that provides coverage under Part C or Part D of Title XVIII of the Social Security Act, as amended from time to time, to residents of this state;

(iv) A third-party administrator, as defined in section 38a-720;

(v) A pharmacy benefits manager, as defined in section 38a-479aaa;

(vi) A hospital service corporation, as defined in section 38a-199;

(vii) A nonprofit medical service corporation, as defined in section 38a-214;

(viii) A fraternal benefit society, as described in section 38a-595, that transacts health insurance business in this state;

(ix) A dental plan organization, as defined in section 38a-577;

(x) A preferred provider network, as defined in section 38a-479aa; and

(xi) Any other person that administers health care claims and payments pursuant to a contract or agreement or is required by statute to administer such claims and payments.

(B) "Reporting entity" does not include an employee welfare benefit plan, as defined in the federal Employee Retirement Income Security Act of 1974, as amended from time to time, that is also a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act.

(3) "Medicaid data" means the Medicaid provider registry, health claims data and Medicaid recipient data maintained by the Department of Social Services.

(b) (1) There is established an all-payer claims database program. The **[**Health Information Technology Officer, designated under section 19a-755,**]** Office of Health Strategy shall: (A) Oversee the planning, implementation and administration of the all-payer claims database program for the purpose of collecting, assessing and reporting health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care; (B) ensure that data received is securely collected, compiled and stored in accordance with state and federal law; **[**and**]** (C) conduct audits of data submitted by reporting entities in order to verify its accuracy; and (D) in consultation with the Health Information Technology Advisory Council established under section 17b-59f, as amended by this act, maintain written procedures for the administration of such all-payer claims database. Any such written procedures shall include (i) reporting requirements for reporting entities, and (ii) requirements for providing notice to a reporting entity regarding any alleged failure on the part of such reporting entity to comply with such reporting requirements.

(2) The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy shall seek funding from the federal

government, other public sources and other private sources to cover costs associated with the planning, implementation and administration of the all-payer claims database program.

(3) (A) Upon the adoption of reporting requirements as set forth in subsection (b) of **[**section 19a-755**]** this section**,** a reporting entity shall report health care information for inclusion in the all-payer claims database in a form and manner prescribed by the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy. The **[**Health Information Technology Officer**]** executive director may, after notice and hearing, impose a civil penalty on any reporting entity that fails to report health care information as prescribed. Such civil penalty shall not exceed one thousand dollars per day for each day of violation and shall not be imposed as a cost for the purpose of rate determination or reimbursement by a third-party payer.

(B) The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy may provide the name of any reporting entity on which such penalty has been imposed to the Insurance Commissioner. After consultation with said **[**officer**]** executive director, the commissioner may request the Attorney General to bring an action in the superior court for the judicial district of Hartford to recover any penalty imposed pursuant to subparagraph (A) of this subdivision.

(4) The Commissioner of Social Services shall submit Medicaid data to the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy for inclusion in the all-payer claims database only for purposes related to administration of the State Medicaid Plan, in accordance with 42 CFR 431.301 to 42 CFR 431.306, inclusive.

(5) The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy shall: (A) Utilize data in the all-payer claims database to provide health care consumers in the state with information concerning the cost and quality of health care services for the purpose of allowing such consumers to make economically sound and medically appropriate health care decisions; and (B) make data in

the all-payer claims database available to any state agency, insurer, employer, health care provider, consumer of health care services or researcher for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services. If health information, as defined in 45 CFR 160.103, as amended from time to time, is permitted to be disclosed under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, or regulations adopted thereunder, any disclosure thereof made pursuant to this subdivision shall have identifiers removed, as set forth in 45 CFR 164.514, as amended from time to time. Any disclosure made pursuant to this subdivision of information other than health information shall be made in a manner to protect the confidentiality of such other information as required by state and federal law. The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy may set a fee to be charged to each person or entity requesting access to data stored in the all-payer claims database.

(6) The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy may (A) in consultation with the All-Payer Claims Database Advisory Group set forth in section 17b-59f, as amended by this act, enter into a contract with a person or entity to plan, implement or administer the all-payer claims database program, (B) enter into a contract or take any action that is necessary to obtain data that is the same data required to be submitted by reporting entities under Medicare Part A or Part B, (C) enter into a contract for the collection, management or analysis of data received from reporting entities, and (D) in accordance with subdivision (4) of this subsection, enter into a contract or take any action that is necessary to obtain Medicaid data. Any such contract for the collection, management or analysis of such data shall expressly prohibit the disclosure of such data for purposes other than the purposes described in this subsection.

(c) Unless otherwise specified, nothing in this section and no action taken by the executive director of the Office of Health Strategy pursuant to this section or section 19a-755b, as amended by this act,

shall be construed to preempt, supersede or affect the authority of the Insurance Commissioner to regulate the business of insurance in the state.

Sec. 59. Section 19a-755b of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) For purposes of this section and sections 19a-904a, 19a-904b and 38a-477d to 38a-477f, inclusive:

(1) "Allowed amount" means the maximum reimbursement dollar amount that an insured's health insurance policy allows for a specific procedure or service;

(2) "Consumer health information Internet web site" means an Internet web site developed and operated by the **[**Health Information Technology Officer**]** Office of Health Strategy to assist consumers in making informed decisions concerning their health care and informed choices among health care providers;

(3) "Episode of care" means all health care services related to the treatment of a condition or a service category for such treatment and, for acute conditions, includes health care services and treatment provided from the onset of the condition to its resolution or a service category for such treatment and, for chronic conditions, includes health care services and treatment provided over a given period of time or a service category for such treatment;

(4) "Executive director" means the executive director of the Office of Health Strategy;

[(4)**]** (5) "Health care provider" means any individual, corporation, facility or institution licensed by this state to provide health care services;

[(5)**]** (6) "Health carrier" means any insurer, health care center, hospital service corporation, medical service corporation, fraternal

benefit society or other entity delivering, issuing for delivery, renewing, amending or continuing any individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

[(6) "Health Information Technology Officer" means the individual designated pursuant to section 19a-755;**]**

(7) "Hospital" has the same meaning as provided in section 19a-490, as amended by this act;

(8) "Out-of-pocket costs" means costs that are not reimbursed by a health insurance policy and includes deductibles, coinsurance and copayments for covered services and other costs to the consumer associated with a procedure or service;

(9) "Outpatient surgical facility" has the same meaning as provided in section 19a-493b, as amended by this act; and

(10) "Public or private third party" means the state, the federal government, employers, a health carrier, third-party administrator, as defined in section 38a-720, or managed care organization.

(b) (1) Within available resources, the consumer health information Internet web site shall: (A) Contain information comparing the quality, price and cost of health care services, including, to the extent practicable, (i) comparative price and cost information for the health care services and procedures reported pursuant to subsection (c) of this section categorized by payer or listed by health care provider, (ii) links to Internet web sites and consumer tools where consumers may obtain comparative cost and quality information, including The Joint Commission and Medicare hospital compare tool, (iii) definitions of common health insurance and medical terms so consumers may compare health coverage and understand the terms of their coverage, and (iv) factors consumers should consider when choosing an insurance product or provider group, including provider network, premium, cost sharing, covered services and tier information; (B) be

designed to assist consumers and institutional purchasers in making informed decisions regarding their health care and informed choices among health care providers and, to the extent practicable, provide reference pricing for services paid by various health carriers to health care providers; (C) present information in language and a format that is understandable to the average consumer; and (D) be publicized to the general public. All information outlined in this section shall be posted on an Internet web site established, or to be established, by the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy in a manner and time frame as may be organizationally and financially reasonable in his or her sole discretion.

(2) Information collected, stored and published by the **[**exchange**]** Office of Health Strategy pursuant to this section is subject to the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time.

(3) The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy may consider adding quality measures to the consumer health information Internet web site. **[**as recommended by the State Innovation Model Initiative program management office.**]**

(c) Not later than January 1, 2018, and annually thereafter, the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy shall, to the extent the information is available, make available to the public on the consumer health information Internet web site a list of: (1) The fifty most frequently occurring inpatient services or procedures in the state; (2) the fifty most frequently provided outpatient services or procedures in the state; (3) the twenty-five most frequent surgical services or procedures in the state; (4) the twenty-five most frequent imaging services or procedures in the state; and (5) the twenty-five most frequently used pharmaceutical products and medical devices in the state. Such lists may (A) be expanded to include additional admissions and

procedures, (B) be based upon those services and procedures that are most commonly performed by volume or that represent the greatest percentage of related health care expenditures, or (C) be designed to include those services and procedures most likely to result in out-of-pocket costs to consumers or include bundled episodes of care.

(d) Not later than January 1, 2018, and annually thereafter, to the extent practicable, the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy shall issue a report, in a manner to be decided by the **[**officer**]** executive director, that includes the (1) billed and allowed amounts paid to health care providers in each health carrier's network for each service and procedure service included pursuant to subsection (c) of this section, and (2) out-of-pocket costs for each such service and procedure.

(e) (1) On and after January 1, 2018, each hospital shall, at the time of scheduling a service or procedure for nonemergency care that is included in the report prepared by the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy pursuant to subsection (c) of this section, regardless of the location or setting where such services are delivered, notify the patient of the patient's right to make a request for cost and quality information. Upon the request of a patient for a diagnosis or procedure included in such report, the hospital shall, not later than three business days after scheduling such service or procedure, provide written notice, electronically or by mail, to the patient who is the subject of the service or procedure concerning: (A) If the patient is uninsured, the amount to be charged for the service or procedure if all charges are paid in full without a public or private third party paying any portion of the charges, including the amount of any facility fee, or, if the hospital is not able to provide a specific amount due to an inability to predict the specific treatment or diagnostic code, the estimated maximum allowed amount or charge for the service or procedure, including the amount of any facility fee; (B) the corresponding Medicare reimbursement amount or, if there is no corresponding Medicare reimbursement amount for such diagnosis or procedure, (i) the approximate amount

Medicare would have paid the hospital for the services on the billing statement, or (ii) the percentage of the hospital's charges that Medicare would have paid the hospital for the services; (C) if the patient is insured, the allowed amount, the toll-free telephone number and the Internet web site address of the patient's health carrier where the patient can obtain information concerning charges and out-of-pocket costs; (D) The Joint Commission's composite accountability rating and the Medicare hospital compare star rating for the hospital, as applicable; and (E) the Internet web site addresses for The Joint Commission and the Medicare hospital compare tool where the patient may obtain information concerning the hospital.

(2) If the patient is insured and the hospital is out-of-network under the patient's health insurance policy, such written notice shall include a statement that the service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply.

Sec. 60. Subsection (a) of section 38a-477e of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) On and after January 1, 2017, each health carrier, as defined in section 19a-755b, as amended by this act, shall maintain an Internet web site and toll-free telephone number that enables consumers to request and obtain: (1) Information on in-network costs for inpatient admissions, health care procedures and services, including (A) the allowed amount for, at a minimum, admissions and procedures reported to the **[**exchange**]** executive director of the Office of Health Strategy pursuant to section 19a-755b, as amended by this act, for each health care provider in the state; (B) the estimated out-of-pocket costs that a consumer would be responsible for paying for any such admission or procedure that is medically necessary, including any facility fee, coinsurance, copayment, deductible or other out-of-pocket expense; and (C) data or other information concerning (i) quality measures for the health care provider, (ii) patient satisfaction, to the

extent such information is available, (iii) a directory of participating providers, as defined in section 38a-472f, in accordance with the provisions of section 38a-477h; and (2) information on out-of-network costs for inpatient admissions, health care procedures and services.

Sec. 61. Section 17b-59a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) As used in this section:

(1) "Electronic health information system" means an information processing system, involving both computer hardware and software that deals with the storage, retrieval, sharing and use of health care information, data and knowledge for communication and decision making, and includes: (A) An electronic health record that provides access in real time to a patient's complete medical record; (B) a personal health record through which an individual, and anyone authorized by such individual, can maintain and manage such individual's health information; (C) computerized order entry technology that permits a health care provider to order diagnostic and treatment services, including prescription drugs electronically; (D) electronic alerts and reminders to health care providers to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments; (E) error notification procedures that generate a warning if an order is entered that is likely to lead to a significant adverse outcome for a patient; and (F) tools to allow for the collection, analysis and reporting of data on adverse events, near misses, the quality and efficiency of care, patient satisfaction and other healthcare-related performance measures.

(2) "Interoperability" means the ability of two or more systems or components to exchange information and to use the information that has been exchanged and includes: (A) The capacity to physically connect to a network for the purpose of exchanging data with other users; and (B) the capacity of a connected user to access, transmit, receive and exchange usable information with other users.

(3) "Standard electronic format" means a format using open electronic standards that: (A) Enable health information technology to be used for the collection of clinically specific data; (B) promote the interoperability of health care information across health care settings, including reporting to local, state and federal agencies; and (C) facilitate clinical decision support.

(b) The Commissioner of Social Services, in consultation with the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy, established under section 19a-754a, as amended by this act, shall (1) develop, throughout the Departments of Developmental Services, Public Health, Correction, Children and Families, Veterans Affairs and Mental Health and Addiction Services, uniform management information, uniform statistical information, uniform terminology for similar facilities, uniform electronic health information technology standards and uniform regulations for the licensing of human services facilities, (2) plan for increased participation of the private sector in the delivery of human services, (3) provide direction and coordination to federally funded programs in the human services agencies and recommend uniform system improvements and reallocation of physical resources and designation of a single responsibility across human services agencies lines to facilitate shared services and eliminate duplication.

(c) The **[**Health Information Technology Officer, designated in accordance with section 19a-755,**]** executive director of the Office of Health Strategy shall, in consultation with the Commissioner of Social Services and the Health Information Technology Advisory Council, established pursuant to section 17b-59f, as amended by this act, implement and periodically revise the state-wide health information technology plan established pursuant to this section and shall establish electronic data standards to facilitate the development of integrated electronic health information systems for use by health care providers and institutions that receive state funding. Such electronic data standards shall: (1) Include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission

protocols; (2) limit the use and dissemination of an individual's Social Security number and require the encryption of any Social Security number provided by an individual; (3) require privacy standards no less stringent than the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and contained in 45 CFR 160, 164; (4) require that individually identifiable health information be secure and that access to such information be traceable by an electronic audit trail; (5) be compatible with any national data standards in order to allow for interstate interoperability; (6) permit the collection of health information in a standard electronic format; and (7) be compatible with the requirements for an electronic health information system.

(d) The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy shall, within existing resources and in consultation with the State Health Information Technology Advisory Council: (1) Oversee the development and implementation of the State-wide Health Information Exchange in conformance with section 17b-59d, as amended by this act; (2) coordinate the state's health information technology and health information exchange efforts to ensure consistent and collaborative cross-agency planning and implementation; and (3) serve as the state liaison to, and work collaboratively with, the State-wide Health Information Exchange established pursuant to section 17b-59d, as amended by this act, to ensure consistency between the state-wide health information technology plan and the State-wide Health Information Exchange and to support the state's health information technology and exchange goals.

(e) The state-wide health information technology plan, implemented and periodically revised pursuant to subsection (c) of this section, shall enhance interoperability to support optimal health outcomes and include, but not be limited to (1) general standards and protocols for health information exchange, and (2) national data standards to support secure data exchange data standards to facilitate the

development of a state-wide, integrated electronic health information system for use by health care providers and institutions that are licensed by the state. Such electronic data standards shall (A) include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission protocols, (B) be compatible with any national data standards in order to allow for interstate interoperability, (C) permit the collection of health information in a standard electronic format, and (D) be compatible with the requirements for an electronic health information system.

(f) Not later than February 1, 2017, and annually thereafter, the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy, in consultation with the State Health Information Technology Advisory Council, shall report in accordance with the provisions of section 11-4a to the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health concerning: (1) The development and implementation of the state-wide health information technology plan and data standards, established and implemented by the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy pursuant to this section; (2) the establishment of the State-wide Health Information Exchange; and (3) recommendations for policy, regulatory and legislative changes and other initiatives to promote the state's health information technology and exchange goals.

Sec. 62. Section 17b-59c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) Matters of policy related to subsection (b) of section 17b-59a, as amended by this act, involving more than one of the agencies designated in **[**section 17b-59a**]** said subsection shall be presented to the Commissioner of Social Services for his or her approval prior to implementation.

(b) Matters of program development related to subsection (b) of section 17b-59a, as amended by this act, involving more than one of the agencies designated in **[**section 17b-59a**]** said subsection shall be

presented to the commissioner for his or her approval prior to implementation.

(c) Any plan of any agency designated in subsection (b) of section 17b-59a, as amended by this act, for the future use or development of property or other resources for the purposes of said subsection shall be submitted to the commissioner for his or her approval prior to implementation.

[(d) Any plan of any agency designated in section 17b-59a for revision of the health information technology plan shall be submitted to the commissioner for his or her approval prior to implementation. If such approval requires funding, after the commissioner has granted approval, the commissioner shall submit such revisions to the Secretary of the Office of Policy and Management.

(e) On or before January 1, 2015, and annually thereafter, the commissioner shall submit, in accordance with the provisions of section 11-4a, the state-wide health information technology plan, as revised in accordance with section 17b-59a, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies.**]**

Sec. 63. Subdivision (1) of subsection (d) of section 17b-59d of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(d) (1) The **[**Health Information Technology Officer, designated in accordance with section 19a-755**]** executive director of the Office of Health Strategy, in consultation with the Secretary of the Office of Policy and Management and the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, as amended by this act, shall, upon the approval by the State Bond Commission of bond funds authorized by the General Assembly for the purposes of establishing a State-wide Health Information Exchange, develop and issue a request for proposals for the development, management and

operation of the State-wide Health Information Exchange. Such request shall promote the reuse of any and all enterprise health information technology assets, such as the existing Provider Directory, Enterprise Master Person Index, Direct Secure Messaging Health Information Service provider infrastructure, analytic capabilities and tools that exist in the state or are in the process of being deployed. Any enterprise health information exchange technology assets purchased after June 2, 2016, and prior to the implementation of the State-wide Health Information Exchange shall be capable of interoperability with a State-wide Health Information Exchange.

Sec. 64. Subsection (f) of section 17b-59d of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(f) The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy shall have administrative authority over the State-wide Health Information Exchange. The **[**Health Information Technology Officer**]** executive director shall be responsible for designating, and posting on its Internet web site, the list of systems, technologies, entities and programs that shall constitute the State-wide Health Information Exchange. Systems, technologies, entities, and programs that have not been so designated shall not be considered part of said exchange.

Sec. 65. Section 17b-59f of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) There shall be a State Health Information Technology Advisory Council to advise the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy and the health information technology officer, designated in accordance with section **[**19a-755**]** 19a-754a, as amended by this act, in developing priorities and policy recommendations for advancing the state's health information technology and health information exchange efforts and goals and to advise the **[**Health Information Technology Officer**]**

executive director and officer in the development and implementation of the state-wide health information technology plan and standards and the State-wide Health Information Exchange, established pursuant to section 17b-59d, as amended by this act. The advisory council shall also advise the **[**Health Information Technology Officer**]** executive director and officer regarding the development of appropriate governance, oversight and accountability measures to ensure success in achieving the state's health information technology and exchange goals.

(b) The council shall consist of the following members:

(1) **[**The Health Information Technology Officer, appointed in accordance with section 19a-755, or the Health Information Technology Officer's designee;**]** One member appointed by the executive director of the Office of Health Strategy, who shall be an expert in state health care reform initiatives;

(2) The health information technology officer, designated in accordance with section 19a-754a, as amended by this act, or the health information technology officer's designee;

[(2)**]** (3) The Commissioners of Social Services, Mental Health and Addiction Services, Children and Families, Correction, Public Health and Developmental Services, or the commissioners' designees;

[(3)**]** (4) The Chief Information Officer of the state, or the Chief Information Officer's designee;

[(4)**]** (5) The chief executive officer of the Connecticut Health Insurance Exchange, or the chief executive officer's designee;

[(5) The director of the state innovation model initiative program management office, or the director's designee;**]**

(6) The chief information officer of The University of Connecticut Health Center, or **[**said**]** the chief information officer's designee;

(7) The Healthcare Advocate, or the Healthcare Advocate's designee;

(8) The Comptroller, or the Comptroller's designee;

(9) Five members appointed by the Governor, one each **[**of whom**]** who shall be (A) a representative of a health system that includes more than one hospital, (B) a representative of the health insurance industry, (C) an expert in health information technology, (D) a health care consumer or consumer advocate, and (E) a current or former employee or trustee of a plan established pursuant to subdivision (5) of subsection (c) of 29 USC 186;

(10) Three members appointed by the president pro tempore of the Senate, one each who shall be (A) a representative of a federally qualified health center, (B) a provider of behavioral health services, and (C) a **[**representative of the Connecticut State Medical Society**]** physician licensed under chapter 370;

(11) Three members appointed by the speaker of the House of Representatives, one each who shall be (A) a technology expert who represents a hospital system, as defined in section 19a-486i, as amended by this act, (B) a provider of home health care services, and (C) a health care consumer or a health care consumer advocate;

(12) One member appointed by the majority leader of the Senate, who shall be a representative of an independent community hospital;

(13) One member appointed by the majority leader of the House of Representatives, who shall be a physician who provides services in a multispecialty group and who is not employed by a hospital;

(14) One member appointed by the minority leader of the Senate, who shall be a primary care physician who provides services in a small independent practice;

(15) One member appointed by the minority leader of the House of Representatives, who shall be an expert in health care analytics and

quality analysis;

(16) The president pro tempore of the Senate, or the president's designee;

(17) The speaker of the House of Representatives, or the speaker's designee;

(18) The minority leader of the Senate, or the minority leader's designee; and

(19) The minority leader of the House of Representatives, or the minority leader's designee.

(c) Any member appointed or designated under subdivisions (10) to (19), inclusive, of subsection (b) of this section may be a member of the General Assembly.

(d) (1) The **[**Health Information Technology Officer, appointed in accordance with section 19a-755**]** health information technology officer, designated in accordance with section 19a-754a, as amended by this act, shall serve as a chairperson of the council. The council shall elect a second chairperson from among its members, who shall not be a state official. The chairpersons of the council may establish subcommittees and working groups and may appoint individuals other than members of the council to serve as members of the subcommittees or working groups. The terms of the members shall be coterminous with the terms of the appointing authority for each member and subject to the provisions of section 4-1a. If any vacancy occurs on the council, the appointing authority having the power to make the appointment under the provisions of this section shall appoint a person in accordance with the provisions of this section. A majority of the members of the council shall constitute a quorum. Members of the council shall serve without compensation, but shall be reimbursed for all reasonable expenses incurred in the performance of their duties.

(2) The chairpersons of the council may appoint up to four additional members to the council, who shall serve at the pleasure of

the chairpersons.

(e) (1) The council shall establish a working group to be known as the All-Payer Claims Database Advisory Group. Said group shall include, but need not be limited to, (A) the Secretary of the Office of Policy and Management, the Comptroller, the Commissioners of Public Health, Social Services and Mental Health and Addiction Services, the Insurance Commissioner, the Healthcare Advocate and the Chief Information Officer, or their designees; (B) a representative of the Connecticut State Medical Society; and (C) representatives of health insurance companies, health insurance purchasers, hospitals, consumer advocates and health care providers. The **[**Health Information Technology Officer**]** health information technology officer may appoint additional members to said group.

(2) The All-Payer Claims Database Advisory Group shall develop a plan to implement a state-wide multipayer data initiative to enhance the state's use of heath care data from multiple sources to increase efficiency, enhance outcomes and improve the understanding of health care expenditures in the public and private sectors.

(f) Prior to submitting any application, proposal, planning document or other request seeking federal grants, matching funds or other federal support for health information technology or health information exchange, the **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy or the Commissioner of Social Services shall present such application, proposal, document or other request to the council for review and comment.

Sec. 66. Section 17b-59g of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) The state, acting by and through the Secretary of the Office of Policy and Management, in collaboration with the **[**Health Information Technology Officer designated under section 19a-755, and the Lieutenant Governor**]** executive director of the Office of Health

Strategy, shall establish a program to expedite the development of the State-wide Health Information Exchange, established under section 17b-59d, as amended by this act, to assist the state, health care providers, insurance carriers, physicians and all stakeholders in empowering consumers to make effective health care decisions, promote patient-centered care, improve the quality, safety and value of health care, reduce waste and duplication of services, support clinical decision-making, keep confidential health information secure and make progress toward the state's public health goals. The purposes of the program shall be to (1) assist the State-wide Health Information Exchange in establishing and maintaining itself as a neutral and trusted entity that serves the public good for the benefit of all Connecticut residents, including, but not limited to, Connecticut health care consumers and Connecticut health care providers and carriers, (2) perform, on behalf of the state, the role of intermediary between public and private stakeholders and customers of the State-wide Health Information Exchange, and (3) fulfill the responsibilities of the Office of Health Strategy, as described in section 19a-754a, as amended by this act.

(b) The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy, in consultation with the health information technology officer, designated in accordance with section 19a-754, as amended by this act, shall design, and the Secretary of the Office of Policy and Management, in collaboration with said **[**officer**]** executive director, may establish or incorporate an entity to implement the program established under subsection (a) of this section. Such entity shall, without limitation, be owned and governed, in whole or in part, by a party or parties other than the state and may be organized as a nonprofit entity.

(c) Any entity established or incorporated pursuant to subsection (b) of this section shall have its powers vested in and exercised by a board of directors. The board of directors shall be comprised of the following members who shall each serve for a term of two years:

(1) One member who shall have expertise as an advocate for consumers of health care, appointed by the Governor;

(2) One member who shall have expertise as a clinical medical doctor, appointed by the president pro tempore of the Senate;

(3) One member who shall have expertise in the area of hospital administration, appointed by the speaker of the House of Representatives;

(4) One member who shall have expertise in the area of corporate law or finance, appointed by the minority leader of the Senate;

(5) One member who shall have expertise in group health insurance coverage, appointed by the minority leader of the House of Representatives;

(6) The Chief Information Officer **[**,**]** and the Secretary of the Office of Policy and Management, **[**and the Health Information Technology Officer,**]** or their designees, who shall serve as ex-officio, voting members of the board; and

(7) The **[**Health Information Technology Officer, or his or her designee**]** health information technology officer, designated in accordance with section 19a-754a, as amended by this act, who shall serve as chairperson of the board.

(d) **[**All initial appointments shall be made not later than February 1, 2018.**]** Any vacancy shall be filled by the appointing authority for the balance of the unexpired term. If an appointing authority fails to make an initial appointment on or before sixty days after the establishment of such entity, or to fill a vacancy in an appointment on or before sixty days after the date of such vacancy, the Governor shall make such appointment or fill such vacancy.

(e) **[**The**]** Any entity established or incorporated under subsection **[**(c)**]** (b) of this section may (1) employ a staff and fix their duties, qualifications and compensation; (2) solicit, receive and accept aid or

contributions, including money, property, labor and other things of value from any source; (3) receive, and manage on behalf of the state, funding from the federal government, other public sources or private sources to cover costs associated with the planning, implementation and administration of the State-wide Health Information Exchange; (4) collect and remit fees set by the Health Information Technology Officer charged to persons or entities for access to or interaction with said exchange; (5) retain outside consultants and technical experts; (6) maintain an office in the state at such place or places as such entity may designate; (7) procure insurance against loss in connection with such entity's property and other assets in such amounts and from such insurers as such entity deems desirable; (8) sue and be sued and plead and be impleaded; (9) borrow money for the purpose of obtaining working capital; and (10) subject to the powers, purposes and restrictions of sections 17b-59a, as amended by this act, 17b-59d, as amended by this act, and 17b-59f, as amended by this act, **[**and 19a-755,**]** do all acts and things necessary and convenient to carry out the purposes of this section and section 19a-754a, as amended by this act.

Sec. 67. Subsection (b) of section 2-124a of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(b) Appointments to the working group pursuant to subsection (a) of this section shall include, but need not be limited to, the **[**Health Information Technology Officer, designated in accordance with section 19a-755**]** executive director of the Office of Health Strategy, or such executive director's designee, and representatives from the insurance industry, the health care industry, the Connecticut Education Network, broadband Internet service providers, the Connecticut Technology Council, the bioscience industry and public or private universities and research institutions. The working group shall also include the Consumer Counsel, or the Consumer Counsel's designee. All appointments to the working group shall be made not later than thirty days after June 30, 2017. Any member of the working group established pursuant to this section may be a member of the working

group established pursuant to special act 16-20 or a member of the General Assembly or the Commission on Economic Competitiveness.

Sec. 68. Section 19a-612 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) There is established, within the **[**Department of Public Health, a division**]** Office of Health Strategy, established under section 19a-754a, as amended by this act, a unit to be known as the **[**Office of Health Care Access**]** Health Systems Planning Unit. The **[**division**]** unit, under the direction of the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy, shall constitute a successor to the former Office of Health Care Access, in accordance with the provisions of sections 4-38d and 4-39.

(b) Any order, decision, agreed settlement **[**,**]** or regulation of the former Office of Health Care Access which is in force on **[**October 6, 2009**]** July 1, 2018, shall continue in force and effect as an order or regulation of the **[**Department of Public Health**]** Office of Health Strategy until amended, repealed or superseded pursuant to law.

(c) If the words "Office of Health Care Access" are used or referred to in any public or special act of 2009 or in any section of the general statutes which is amended in 2009, such words shall be deemed to mean or refer to the Office of Health Care Access division within the Department of Public Health. If the words "Office of Health Care Access" are used or referred to in any public or special act of 2018 or in any section of the general statutes which is amended in 2018, such words shall be deemed to mean or refer to the Health Systems Planning Unit within the Office of Health Strategy.

Sec. 69. Section 19a-612d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) **[**Notwithstanding any provision of the general statutes, there shall be a Deputy Commissioner of Public Health who**]** The executive director of the Office of Health Strategy shall oversee the **[**Office of

Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit and **[**who**]** shall exercise independent decision-making authority over all certificate of need decisions.

(b) Notwithstanding the provisions of subsection (a) of this section, the Deputy Commissioner of Public Health shall retain independent decision-making authority over only the certificate of need applications that are pending before the Office of Health Care Access and have been deemed completed by said office on or before July 1, 2018. Following the issuance by the deputy commissioner of a final decision on any such certificate of need application, the executive director of the Office of Health Strategy shall exercise independent authority on any further action required on a certificate of need issued pursuant to such application.

Sec. 70. Section 19a-613 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) The **[**Office of Health Care Access**]** Health Systems Planning Unit may employ the most effective and practical means necessary to fulfill the purposes of this chapter, which may include, but need not be limited to:

(1) Collecting patient-level outpatient data from health care facilities or institutions, as defined in section 19a-630, as amended by this act;

(2) Establishing a cooperative data collection effort, across public and private sectors, to assure that adequate health care personnel demographics are readily available; and

(3) Performing the duties and functions as enumerated in subsection (b) of this section.

(b) The **[**office**]** unit shall: (1) Authorize and oversee the collection of data required to carry out the provisions of this chapter; (2) oversee and coordinate health system planning for the state; (3) monitor health care costs; and (4) implement and oversee health care reform as enacted by the General Assembly.

(c) The [Commissioner of Public Health] executive director of the Office of Health Strategy, or any person the [commissioner] executive director designates, may conduct a hearing and render a final decision in any case when a hearing is required or authorized under the provisions of any statute dealing with the [Office of Health Care Access] Health Systems Planning Unit.

Sec. 71. Section 19a-614 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

[(a)] The [Commissioner of Public Health] executive director of the Office of Health Strategy may employ and pay professional and support staff subject to the provisions of chapter 67 and contract with and engage consultants and other independent professionals as may be necessary or desirable to carry out the functions of the [office] Health Systems Planning Unit.

[(b) The commissioner may establish a consumer education unit within the office to provide information to residents of the state concerning the availability of public and private health care coverage.]

Sec. 72. Section 19a-630 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

As used in this chapter, unless the context otherwise requires:

(1) "Affiliate" means a person, entity or organization controlling, controlled by or under common control with another person, entity or organization. Affiliate does not include a medical foundation organized under chapter 594b.

(2) "Applicant" means any person or health care facility that applies for a certificate of need pursuant to section 19a-639a, as amended by this act.

(3) "Bed capacity" means the total number of inpatient beds in a facility licensed by the Department of Public Health under sections 19a-490 to 19a-503, inclusive, as amended by this act.

(4) "Capital expenditure" means an expenditure that under generally accepted accounting principles consistently applied is not properly chargeable as an expense of operation or maintenance and includes acquisition by purchase, transfer, lease or comparable arrangement, or through donation, if the expenditure would have been considered a capital expenditure had the acquisition been by purchase.

(5) "Certificate of need" means a certificate issued by the **[**office**]** unit.

(6) "Days" means calendar days.

[(7) "Deputy commissioner" means the deputy commissioner of Public Health who oversees the Office of Health Care Access division of the Department of Public Health.

(8) "Commissioner" means the Commissioner of Public Health.**]**

(7) "Executive director" means the executive director of the Office of Health Strategy.

[(9)**]** (8) "Free clinic" means a private, nonprofit community-based organization that provides medical, dental, pharmaceutical or mental health services at reduced cost or no cost to low-income, uninsured and underinsured individuals.

[(10)**]** (9) "Large group practice" means eight or more full-time equivalent physicians, legally organized in a partnership, professional corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity (A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated

as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians.

[(11)**]** (10) "Health care facility" means (A) hospitals licensed by the Department of Public Health under chapter 368v; (B) specialty hospitals; (C) freestanding emergency departments; (D) outpatient surgical facilities, as defined in section 19a-493b, as amended by this act, and licensed under chapter 368v; (E) a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended; (F) a central service facility; (G) mental health facilities; (H) substance abuse treatment facilities; and (I) any other facility requiring certificate of need review pursuant to subsection (a) of section 19a-638, as amended by this act. "Health care facility" includes any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility.

[(12)**]** (11) "Nonhospital based" means located at a site other than the main campus of the hospital.

[(13)**]** (12) "Office" means the Office of Health **[**Care Access division within the Department of Public Health**]** Strategy.

[(14)**]** (13) "Person" means any individual, partnership, corporation, limited liability company, association, governmental subdivision, agency or public or private organization of any character, but does not include the agency conducting the proceeding.

[(15)**]** (14) "Physician" has the same meaning as provided in section 20-13a.

[(16)**]** (15) "Transfer of ownership" means a transfer that impacts or changes the governance or controlling body of a health care facility, institution or large group practice, including, but not limited to, all affiliations, mergers or any sale or transfer of net assets of a health care facility.

(16) "Unit" means the Health Systems Planning Unit.

Sec. 73. Subsection (b) of section 19a-631 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(b) Each hospital shall annually pay to the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy, for deposit in the General Fund, an amount equal to its share of the actual expenditures made by the **[**office**]** unit during each fiscal year including the cost of fringe benefits for **[**office**]** unit personnel as estimated by the Comptroller, the amount of expenses for central state services attributable to the **[**office**]** unit for the fiscal year as estimated by the Comptroller, plus the expenditures made on behalf of the **[**office**]** unit from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year. Payments shall be made by assessment of all hospitals of the costs calculated and collected in accordance with the provisions of this section and section 19a-632, as amended by this act. If for any reason a hospital ceases operation, any unpaid assessment for the operations of the **[**office**]** unit shall be reapportioned among the remaining hospitals to be paid in addition to any other assessment.

Sec. 74. Section 19a-632 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) On or before September first, annually, the **[**Office of Health Care Access**]** Health Systems Planning Unit shall determine (1) the total net revenue of each hospital for the most recently completed hospital fiscal year beginning October first; and (2) the proposed assessment on the hospital for the state fiscal year. The assessment on each hospital shall be calculated by multiplying the hospital's percentage share of the total

net revenue specified in subdivision (1) of this subsection times the costs of the **[**office**]** unit, as determined in subsection (b) of this section.

(b) The costs of the **[**office**]** unit shall be the total of (1) the amount appropriated for expenses for the operation of the **[**office**]** unit for the fiscal year, as estimated by the Comptroller, (2) the cost of fringe benefits for **[**office**]** unit personnel for such year, as estimated by the Comptroller, (3) the amount of expenses for central state services attributable to the **[**office**]** unit for the fiscal year as estimated by the Comptroller, and (4) the estimated expenditures on behalf of the **[**office**]** unit from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, provided for purposes of this calculation the amount of expenses for the operation of the **[**office**]** unit for the fiscal year as estimated by the Comptroller, plus the cost of fringe benefits for personnel, the amount of expenses for said central state services for the fiscal year as estimated by the Comptroller, and said estimated expenditures from the Capital Equipment Purchase Fund pursuant to section 4a-9 shall be deemed to be the actual expenditures of the **[**office**]** unit.

(c) On or before December thirty-first, annually, for each fiscal year, each hospital shall pay the **[**office**]** unit twenty-five per cent of its proposed assessment, adjusted to reflect any credit or amount due under the recalculated assessment for the preceding state fiscal year as determined pursuant to subsection (d) of this section or any reapportioned assessment pursuant to subsection (b) of section 19a-631, as amended by this act. The hospital shall pay the remaining seventy-five per cent of its assessment to the **[**office**]** unit in three equal installments on or before the following March thirty-first, June thirtieth and September thirtieth, annually.

(d) Immediately following the close of each state fiscal year the **[**commissioner**]** executive director shall recalculate the proposed assessment for each hospital based on the costs of the **[**office**]** unit in accordance with subsection (b) of this section using the actual expenditures made by the **[**office**]** unit during that fiscal year and the

actual expenditures made on behalf of the [office] unit from the Capital Equipment Purchase Fund pursuant to section 4a-9. On or before August thirty-first, annually, the [office] unit shall render to each hospital a statement showing the difference between the respective recalculated assessment and the amount previously paid. On or before September thirtieth, the [commissioner] executive director, after receiving any objections to such statements, shall make such adjustments which in said [commissioner's] executive director's opinion may be indicated and shall render an adjusted assessment, if any, to the affected hospitals. Adjustments to reflect any credit or amount due under the recalculated assessment for the previous state fiscal year shall be made to the proposed assessment due on or before December thirty-first of the following state fiscal year.

(e) If any assessment is not paid when due, the [commissioner] executive director shall impose a fee equal to (1) two per cent of the assessment if such failure to pay is for not more than five days, (2) five per cent of the assessment if such failure to pay is for more than five days but not more than fifteen days, or (3) ten per cent of the assessment if such failure to pay is for more than fifteen days. If a hospital fails to pay any assessment for more than thirty days after the date when due, the [commissioner] executive director may, in addition to the fees imposed pursuant to this subsection, impose a civil penalty of up to one thousand dollars per day for each day past the initial thirty days that the assessment is not paid. Any civil penalty authorized by this subsection shall be imposed by the [commissioner] executive director in accordance with subsections (b) to (e), inclusive, of section 19a-653, as amended by this act.

(f) The [office] unit shall deposit all payments received pursuant to this section with the State Treasurer. The moneys so deposited shall be credited to the General Fund and shall be accounted for as expenses recovered from hospitals.

Sec. 75. Subsection (b) of section 19a-632a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July*

1, 2018):

(b) The **[**Department of Public Health**]** Office of Health Strategy may require a hospital to pay an assessment levied pursuant to section 19a-632, as amended by this act, by way of an approved method of electronic funds transfer.

Sec. 76. Subsection (f) of section 19a-632a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(f) The **[**department**]** office shall deposit all payments received pursuant to this section with the State Treasurer. The moneys so deposited shall be credited to the General Fund and shall be accounted for as expenses recovered from hospitals.

Sec. 77. Section 19a-633 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

The **[**commissioner**]** executive director, or any agent authorized by **[**him**]** such executive director to conduct any inquiry, investigation or hearing under the provisions of this chapter, shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any hearing ordered by the office, the **[**commissioner**]** executive director or such agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to **[**him**]** such person by the **[**commissioner**]** executive director or **[**his**]** such executive director's authorized agent or to produce any records and papers pursuant thereto, the **[**commissioner**]** executive director or **[**his**]** such executive director's agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the business has been conducted, or to any judge of said court if the same is not in session, setting forth such disobedience to process or refusal to answer, and said court or such

judge shall cite such person to appear before said court or such judge to answer such question or to produce such records and papers.

Sec. 78. Section 19a-634 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) The **[**Office of Health Care Access**]** Health Systems Planning Unit shall conduct, on a biennial basis, a state-wide health care facility utilization study. Such study may include an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the **[**office**]** unit deems pertinent to health care facility utilization. Not later than June thirtieth of the year in which the biennial study is conducted, the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy shall report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the **[**office's**]** unit's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access to health care services.

(b) The **[**office**]** unit, in consultation with such other state agencies as the **[**Commissioner of Public Health**]** executive director deems appropriate, shall establish and maintain a state-wide health care facilities and services plan. Such plan may include, but not be limited to: (1) An assessment of the availability of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) an evaluation of the unmet needs of persons at risk and vulnerable populations as determined by the **[**commissioner**]** executive director; (3) a projection of future demand for health care services and the impact that technology may have on the demand, capacity or need for such services; and (4)

recommendations for the expansion, reduction or modification of health care facilities or services. In the development of the plan, the **[**office**]** unit shall consider the recommendations of any advisory bodies which may be established by the **[**commissioner**]** executive director. The **[**commissioner**]** executive director may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The **[**commissioner**]** executive director, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the state-wide health care facilities and services plan into hospital long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The **[**office**]** unit shall update the state-wide health care facilities and services plan not less than once every two years.

(c) For purposes of conducting the state-wide health care facility utilization study and preparing the state-wide health care facilities and services plan, the **[**office**]** unit shall establish and maintain an inventory of all health care facilities, the equipment identified in subdivisions (9) and (10) of subsection (a) of section 19a-638, as amended by this act, and services in the state, including health care facilities that are exempt from certificate of need requirements under subsection (b) of section 19a-638, as amended by this act. The **[**office**]** unit shall develop an inventory questionnaire to obtain the following information: (1) The name and location of the facility; (2) the type of facility; (3) the hours of operation; (4) the type of services provided at that location; and (5) the total number of clients, treatments, patient visits, procedures performed or scans performed in a calendar year. The inventory shall be completed biennially by health care facilities and providers and such health care facilities and providers shall not be required to provide patient specific or financial data.

Sec. 79. Section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) A certificate of need issued by the **[**office**]** unit shall be required for:

(1) The establishment of a new health care facility;

(2) A transfer of ownership of a health care facility;

(3) A transfer of ownership of a large group practice to any entity other than a (A) physician, or (B) group of two or more physicians, legally organized in a partnership, professional corporation or limited liability company formed to render professional services and not employed by or an affiliate of any hospital, medical foundation, insurance company or other similar entity;

(4) The establishment of a freestanding emergency department;

(5) The termination of inpatient or outpatient services offered by a hospital, including, but not limited to, the termination by a short-term acute care general hospital or children's hospital of inpatient and outpatient mental health and substance abuse services;

(6) The establishment of an outpatient surgical facility, as defined in section 19a-493b, as amended by this act, or as established by a short-term acute care general hospital;

(7) The termination of surgical services by an outpatient surgical facility, as defined in section 19a-493b, as amended by this act, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care general hospital, provided termination of outpatient surgical services due to (A) insufficient patient volume, or (B) the termination of any subspecialty surgical service, shall not require certificate of need approval;

(8) The termination of an emergency department by a short-term acute care general hospital;

(9) The establishment of cardiac services, including inpatient and

outpatient cardiac catheterization, interventional cardiology and cardiovascular surgery;

(10) The acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners, by any person, physician, provider, short-term acute care general hospital or children's hospital, except (A) as provided for in subdivision (22) of subsection (b) of this section, and (B) a certificate of need issued by the **[**office**]** unit shall not be required where such scanner is a replacement for a scanner that was previously acquired through certificate of need approval or a certificate of need determination;

(11) The acquisition of nonhospital based linear accelerators;

(12) An increase in the licensed bed capacity of a health care facility;

(13) The acquisition of equipment utilizing technology that has not previously been utilized in the state;

(14) An increase of two or more operating rooms within any three-year period, commencing on and after October 1, 2010, by an outpatient surgical facility, as defined in section 19a-493b, as amended by this act, or by a short-term acute care general hospital; and

(15) The termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended.

(b) A certificate of need shall not be required for:

(1) Health care facilities owned and operated by the federal government;

(2) The establishment of offices by a licensed private practitioner, whether for individual or group practice, except when a certificate of need is required in accordance with the requirements of section 19a-

493b, as amended by this act, or subdivision (3), (10) or (11) of subsection (a) of this section;

(3) A health care facility operated by a religious group that exclusively relies upon spiritual means through prayer for healing;

(4) Residential care homes, nursing homes and rest homes, as defined in subsection (c) of section 19a-490;

(5) An assisted living services agency, as defined in section 19a-490, as amended by this act;

(6) Home health agencies, as defined in section 19a-490, as amended by this act;

(7) Hospice services, as described in section 19a-122b;

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

(11) Free clinics, as defined in section 19a-630, as amended by this act;

(12) School-based health centers and expanded school health sites, as such terms are defined in section 19a-6r, community health centers, as defined in section 19a-490a, not-for-profit outpatient clinics licensed in accordance with the provisions of chapter 368v and federally qualified health centers;

(13) A program licensed or funded by the Department of Children and Families, provided such program is not a psychiatric residential treatment facility;

(14) Any nonprofit facility, institution or provider that has a contract with, or is certified or licensed to provide a service for, a state agency or department for a service that would otherwise require a certificate

of need. The provisions of this subdivision shall not apply to a short-term acute care general hospital or children's hospital, or a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended;

(15) A health care facility operated by a nonprofit educational institution exclusively for students, faculty and staff of such institution and their dependents;

(16) An outpatient clinic or program operated exclusively by or contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district, as described in section 19a-241;

(17) A residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities;

(18) Replacement of existing imaging equipment if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the **[**office**]** unit of the date on which the equipment is replaced and the disposition of the replaced equipment;

(19) Acquisition of cone-beam dental imaging equipment that is to be used exclusively by a dentist licensed pursuant to chapter 379;

(20) The partial or total elimination of services provided by an outpatient surgical facility, as defined in section 19a-493b, as amended by this act, except as provided in subdivision (6) of subsection (a) of this section and section 19a-639e, as amended by this act;

(21) The termination of services for which the Department of Public Health has requested the facility to relinquish its license; or

(22) Acquisition of any equipment by any person that is to be used

exclusively for scientific research that is not conducted on humans.

(c) (1) Any person, health care facility or institution that is unsure whether a certificate of need is required under this section, or (2) any health care facility that proposes to relocate pursuant to section 19a-639c, as amended by this act, shall send a letter to the **[**office**]** unit that describes the project and requests that the **[**office**]** unit make a determination as to whether a certificate of need is required. In the case of a relocation of a health care facility, the letter shall include information described in section 19a-639c, as amended by this act. A person, health care facility or institution making such request shall provide the **[**office**]** unit with any information the **[**office**]** unit requests as part of its determination process.

(d) The **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the **[**commissioner**]** executive director holds a public hearing prior to implementing the policies and procedures and **[**prints**]** posts notice of intent to adopt regulations **[**in the Connecticut Law Journal**]** on the office's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. **[**Final regulations shall be adopted by December 31, 2011.**]**

Sec. 80. Section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, as amended by this act, the **[**office**]** unit shall take into consideration and make written findings concerning each of the following guidelines and principles:

(1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the **[**Department of

Public Health**]** Office of Health Strategy;

(2) The relationship of the proposed project to the state-wide health care facilities and services plan;

(3) Whether there is a clear public need for the health care facility or services proposed by the applicant;

(4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;

(5) Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons;

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;

(7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;

(8) The utilization of existing health care facilities and health care services in the service area of the applicant;

(9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;

(10) Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates

between Medicaid and other health care payers;

(11) Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region; and

(12) Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care.

(b) In deliberations as described in subsection (a) of this section, there shall be a presumption in favor of approving the certificate of need application for a transfer of ownership of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, as amended by this act, when an offer was made in response to a request for proposal or similar voluntary offer for sale.

(c) The **[**office**]** unit, as it deems necessary, may revise or supplement the guidelines and principles, **[**through regulation prescribed in subsection (a) of this section**]** set forth in subsection (a) of this section, through regulation.

(d) (1) For purposes of this subsection and subsection (e) of this section:

(A) "Affected community" means a municipality where a hospital is physically located or a municipality whose inhabitants are regularly served by a hospital;

(B) "Hospital" has the same meaning as provided in section 19a-490, as amended by this act;

(C) "New hospital" means a hospital as it exists after the approval of an agreement pursuant to section 19a-486b, as amended by this act, or a certificate of need application for a transfer of ownership of a hospital;

(D) "Purchaser" means a person who is acquiring, or has acquired,

any assets of a hospital through a transfer of ownership of a hospital;

(E) "Transacting party" means a purchaser and any person who is a party to a proposed agreement for transfer of ownership of a hospital;

(F) "Transfer" means to sell, transfer, lease, exchange, option, convey, give or otherwise dispose of or transfer control over, including, but not limited to, transfer by way of merger or joint venture not in the ordinary course of business; and

(G) "Transfer of ownership of a hospital" means a transfer that impacts or changes the governance or controlling body of a hospital, including, but not limited to, all affiliations, mergers or any sale or transfer of net assets of a hospital and for which a certificate of need application or a certificate of need determination letter is filed on or after December 1, 2015.

(2) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, as amended by this act, that involves the transfer of ownership of a hospital, the **[**office**]** unit shall, in addition to the guidelines and principles set forth in subsection (a) of this section and those prescribed through regulation pursuant to subsection (c) of this section, take into consideration and make written findings concerning each of the following guidelines and principles:

(A) Whether the applicant fairly considered alternative proposals or offers in light of the purpose of maintaining health care provider diversity and consumer choice in the health care market and access to affordable quality health care for the affected community; and

(B) Whether the plan submitted pursuant to section 19a-639a, as amended by this act, demonstrates, in a manner consistent with this chapter, how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services.

(3) The **[**office**]** unit shall deny any certificate of need application

involving a transfer of ownership of a hospital unless the [commissioner] executive director finds that the affected community will be assured of continued access to high quality and affordable health care after accounting for any proposed change impacting hospital staffing.

(4) The [office] unit may deny any certificate of need application involving a transfer of ownership of a hospital subject to a cost and market impact review pursuant to section 19a-639f, as amended by this act, if the [commissioner] executive director finds that (A) the affected community will not be assured of continued access to high quality and affordable health care after accounting for any consolidation in the hospital and health care market that may lessen health care provider diversity, consumer choice and access to care, and (B) any likely increases in the prices for health care services or total health care spending in the state may negatively impact the affordability of care.

(5) The [office] unit may place any conditions on the approval of a certificate of need application involving a transfer of ownership of a hospital consistent with the provisions of this chapter. Before placing any such conditions, the [office] unit shall weigh the value of such conditions in promoting the purposes of this chapter against the individual and cumulative burden of such conditions on the transacting parties and the new hospital. For each condition imposed, the [office] unit shall include a concise statement of the legal and factual basis for such condition and the provision or provisions of this chapter that it is intended to promote. Each condition shall be reasonably tailored in time and scope. The transacting parties or the new hospital shall have the right to make a request to the [office] unit for an amendment to, or relief from, any condition based on changed circumstances, hardship or for other good cause.

(e) (1) If the certificate of need application (A) involves the transfer of ownership of a hospital, (B) the purchaser is a hospital, as defined in section 19a-490, as amended by this act, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an

amount greater than one billion five hundred million dollars or a hospital system, as defined in section 19a-486i, as amended by this act, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars, or any person that is organized or operated for profit, and (C) such application is approved, the **[**office**]** unit shall hire an independent consultant to serve as a post-transfer compliance reporter for a period of three years after completion of the transfer of ownership of the hospital. Such reporter shall, at a minimum: (i) Meet with representatives of the purchaser, the new hospital and members of the affected community served by the new hospital not less than quarterly; and (ii) report to the **[**office**]** unit not less than quarterly concerning (I) efforts the purchaser and representatives of the new hospital have taken to comply with any conditions the **[**office**]** unit placed on the approval of the certificate of need application and plans for future compliance, and (II) community benefits and uncompensated care provided by the new hospital. The purchaser shall give the reporter access to its records and facilities for the purposes of carrying out the reporter's duties. The purchaser shall hold a public hearing in the municipality in which the new hospital is located not less than annually during the reporting period to provide for public review and comment on the reporter's reports and findings.

(2) If the reporter finds that the purchaser has breached a condition of the approval of the certificate of need application, the **[**office**]** unit may, in consultation with the purchaser, the reporter and any other interested parties it deems appropriate, implement a performance improvement plan designed to remedy the conditions identified by the reporter and continue the reporting period for up to one year following a determination by the **[**office**]** unit that such conditions have been resolved.

(3) The purchaser shall provide funds, in an amount determined by the **[**office**]** unit not to exceed two hundred thousand dollars annually, for the hiring of the post-transfer compliance reporter.

(f) Nothing in subsection (d) or (e) of this section shall apply to a transfer of ownership of a hospital in which either a certificate of need application is filed on or before December 1, 2015, or where a certificate of need determination letter is filed on or before December 1, 2015.

Sec. 81. Section 19a-639a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) An application for a certificate of need shall be filed with the **[**office**]** unit in accordance with the provisions of this section and any regulations adopted by the **[**Department of Public Health**]** Office of Health Strategy. The application shall address the guidelines and principles set forth in (1) subsection (a) of section 19a-639, as amended by this act, and (2) regulations adopted by the department. The applicant shall include with the application a nonrefundable application fee of five hundred dollars.

(b) Prior to the filing of a certificate of need application, the applicant shall publish notice that an application is to be submitted to the **[**office**]** unit in a newspaper having a substantial circulation in the area where the project is to be located. Such notice shall (1) be published (A) not later than twenty days prior to the date of filing of the certificate of need application, and (B) for not less than three consecutive days, and (2) contain a brief description of the nature of the project and the street address where the project is to be located. An applicant shall file the certificate of need application with the **[**office**]** unit not later than ninety days after publishing notice of the application in accordance with the provisions of this subsection. The **[**office**]** unit shall not accept the applicant's certificate of need application for filing unless the application is accompanied by the application fee prescribed in subsection (a) of this section and proof of compliance with the publication requirements prescribed in this subsection.

(c) (1) Not later than five business days after receipt of a properly filed certificate of need application, the **[**office**]** unit shall publish notice

of the application on its Internet web site. Not later than thirty days after the date of filing of the application, the office may request such additional information as the [office] unit determines necessary to complete the application. In addition to any information requested by the [office] unit, if the application involves the transfer of ownership of a hospital, as defined in section 19a-639, as amended by this act, the applicant shall submit to the [office] unit (A) a plan demonstrating how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services, and (B) the names of persons currently holding a position with the hospital to be purchased or the purchaser, as defined in section 19a-639, as amended by this act, as an officer, director, board member or senior manager, whether or not such person is expected to hold a position with the hospital after completion of the transfer of ownership of the hospital and any salary, severance, stock offering or any financial gain, current or deferred, such person is expected to receive as a result of, or in relation to, the transfer of ownership of the hospital.

(2) The applicant shall, not later than sixty days after the date of the [office's] unit's request, submit any requested information and any information required under this subsection to the [office] unit. If an applicant fails to submit such information to the [office] unit within the sixty-day period, the [office] unit shall consider the application to have been withdrawn.

(d) Upon determining that an application is complete, the [office] unit shall provide notice of this determination to the applicant and to the public in accordance with regulations adopted by the department. In addition, the [office] unit shall post such notice on its Internet web site. The date on which the [office] unit posts such notice on its Internet web site shall begin the review period. Except as provided in this subsection, (1) the review period for a completed application shall be ninety days from the date on which the [office] unit posts such notice on its Internet web site; and (2) the [office] unit shall issue a decision

on a completed application prior to the expiration of the ninety-day review period. The review period for a completed application that involves a transfer of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, as amended by this act, when the offer was made in response to a request for proposal or similar voluntary offer for sale, shall be sixty days from the date on which the **[**office**]** unit posts notice on its Internet web site. Upon request or for good cause shown, the **[**office**]** unit may extend the review period for a period of time not to exceed sixty days. If the review period is extended, the **[**office**]** unit shall issue a decision on the completed application prior to the expiration of the extended review period. If the **[**office**]** unit holds a public hearing concerning a completed application in accordance with subsection (e) or (f) of this section, the **[**office**]** unit shall issue a decision on the completed application not later than sixty days after the date the **[**office**]** unit closes the public hearing record.

(e) Except as provided in this subsection, the **[**office**]** unit shall hold a public hearing on a properly filed and completed certificate of need application if three or more individuals or an individual representing an entity with five or more people submits a request, in writing, that a public hearing be held on the application. For a properly filed and completed certificate of need application involving a transfer of ownership of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, as amended by this act, when an offer was made in response to a request for proposal or similar voluntary offer for sale, a public hearing shall be held if twenty-five or more individuals or an individual representing twenty-five or more people submits a request, in writing, that a public hearing be held on the application. Any request for a public hearing shall be made to the **[**office**]** unit not later than thirty days after the date the **[**office**]** unit determines the application to be complete.

(f) (1) The **[**office**]** unit shall hold a public hearing with respect to each certificate of need application filed pursuant to section 19a-638, as amended by this act, after December 1, 2015, that concerns any transfer

of ownership involving a hospital. Such hearing shall be held in the municipality in which the hospital that is the subject of the application is located.

(2) The [office] unit may hold a public hearing with respect to any certificate of need application submitted under this chapter. The [office] unit shall provide not less than two weeks' advance notice to the applicant, in writing, and to the public by publication in a newspaper having a substantial circulation in the area served by the health care facility or provider. In conducting its activities under this chapter, the [office] unit may hold hearing on applications of a similar nature at the same time.

(g) The [Commissioner of Public Health] executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the [commissioner] executive director holds a public hearing prior to implementing the policies and procedures and [prints] posts notice of intent to adopt regulations on the [department's] office's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 82. Section 19a-639b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) A certificate of need shall be valid only for the project described in the application. A certificate of need shall be valid for two years from the date of issuance by the [office] unit. During the period of time that such certificate is valid and the thirty-day period following the expiration of the certificate, the holder of the certificate shall provide the [office] unit with such information as the [office] unit may request on the development of the project covered by the certificate.

(b) Upon request from a certificate holder, the [office] unit may

extend the duration of a certificate of need for such additional period of time as the [office] unit determines is reasonably necessary to expeditiously complete the project. Not later than five business days after receiving a request to extend the duration of a certificate of need, the [office] unit shall post such request on its web site. Any person who wishes to comment on extending the duration of the certificate of need shall provide written comments to the [office] unit on the requested extension not later than thirty days after the date the [office] unit posts notice of the request for an extension of time on its web site. The [office] unit shall hold a public hearing on any request to extend the duration of a certificate of need if three or more individuals or an individual representing an entity with five or more people submits a request, in writing, that a public hearing be held on the request to extend the duration of a certificate of need.

(c) In the event that the [office] unit determines that: (1) Commencement, construction or other preparation has not been substantially undertaken during a valid certificate of need period; or (2) the certificate holder has not made a good-faith effort to complete the project as approved, the [office] unit may withdraw, revoke or rescind the certificate of need.

(d) A certificate of need shall not be transferable or assignable nor shall a project be transferred from a certificate holder to another person.

(e) The [Commissioner of Public Health] executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the [commissioner] executive director holds a public hearing prior to implementing the policies and procedures and [prints] posts notice of intent to adopt regulations [in the Connecticut Law Journal] on the office's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until

the time final regulations are adopted. Final regulations shall be adopted by December 31, 2011.

Sec. 83. Section 19a-639c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) Any health care facility that proposes to relocate a facility shall submit a letter to the **[**office**]** unit, as described in subsection (c) of section 19a-638, as amended by this act. In addition to the requirements prescribed in said subsection (c), in such letter the health care facility shall demonstrate to the satisfaction of the **[**office**]** unit that the population served by the health care facility and the payer mix will not substantially change as a result of the facility's proposed relocation. If the facility is unable to demonstrate to the satisfaction of the **[**office**]** unit that the population served and the payer mix will not substantially change as a result of the proposed relocation, the health care facility shall apply for certificate of need approval pursuant to subdivision (1) of subsection (a) of section 19a-638, as amended by this act, in order to effectuate the proposed relocation.

(b) The **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the **[**commissioner**]** executive director holds a public hearing prior to implementing the policies and procedures and **[**prints**]** posts notice of intent to adopt regulations **[**in the Connecticut Law Journal**]** on the office's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. **[**Final regulations shall be adopted by December 31, 2011.**]**

Sec. 84. Section 19a-639e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) Unless otherwise required to file a certificate of need application

pursuant to the provisions of subsection (a) of section 19a-638, as amended by this act, any health care facility that proposes to terminate a service that was authorized pursuant to a certificate of need issued under this chapter shall file a modification request with the [office] unit not later than sixty days prior to the proposed date of the termination of the service. The [office] unit may request additional information from the health care facility as necessary to process the modification request. In addition, the [office] unit shall hold a public hearing on any request from a health care facility to terminate a service pursuant to this section if three or more individuals or an individual representing an entity with five or more people submits a request, in writing, that a public hearing be held on the health care facility's proposal to terminate a service.

(b) Unless otherwise required to file a certificate of need application pursuant to the provisions of subsection (a) of section 19a-638, as amended by this act, any health care facility that proposes to terminate all services offered by such facility, that were authorized pursuant to one or more certificates of need issued under this chapter, shall provide notification to the [office] unit not later than sixty days prior to the termination of services and such facility shall surrender its certificate of need not later than thirty days prior to the termination of services.

(c) Unless otherwise required to file a certificate of need application pursuant to the provisions of subsection (a) of section 19a-638, as amended by this act, any health care facility that proposes to terminate the operation of a facility or service for which a certificate of need was not obtained shall notify the [office] unit not later than sixty days prior to terminating the operation of the facility or service.

(d) The [Commissioner of Public Health] executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the [commissioner] executive director holds a public hearing

prior to implementing the policies and procedures and [prints] posts notice of intent to adopt regulations [in the Connecticut Law Journal] on the office's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. Final regulations shall be adopted by December 31, 2015.

Sec. 85. Section 19a-639f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) The [Office of Healthcare Access division within the Department of Public Health] Health Systems Planning Unit of the Office of Health Strategy shall conduct a cost and market impact review in each case where (1) an application for a certificate of need filed pursuant to section 19a-638, as amended by this act, involves the transfer of ownership of a hospital, as defined in section 19a-639, as amended by this act, and (2) the purchaser is a hospital, as defined in section 19a-490, as amended by this act, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars, or a hospital system, as defined in section 19a-486i, as amended by this act, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars or any person that is organized or operated for profit.

(b) Not later than twenty-one days after receipt of a properly filed certificate of need application involving the transfer of ownership of a hospital filed on or after December 1, 2015, as described in subsection (a) of this section, the [office] unit shall initiate such cost and market impact review by sending the transacting parties a written notice that shall contain a description of the basis for the cost and market impact review as well as a request for information and documents. Not later than thirty days after receipt of such notice, the transacting parties shall submit to the [office] unit a written response. Such response shall include, but need not be limited to, any information or documents

requested by the [office] unit concerning the transfer of ownership of the hospital. The [office] unit shall have the powers with respect to the cost and market impact review as provided in section 19a-633, as amended by this act.

(c) The [office] unit shall keep confidential all nonpublic information and documents obtained pursuant to this section and shall not disclose the information or documents to any person without the consent of the person that produced the information or documents, except in a preliminary report or final report issued in accordance with this section if the [office] unit believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Such information and documents shall not be deemed a public record, under section 1-210, as amended by this act, and shall be exempt from disclosure.

(d) The cost and market impact review conducted pursuant to this section shall examine factors relating to the businesses and relative market positions of the transacting parties as defined in subsection (d) of section 19a-639, as amended by this act, and may include, but need not be limited to: (1) The transacting parties' size and market share within its primary service area, by major service category and within its dispersed service areas; (2) the transacting parties' prices for services, including the transacting parties' relative prices compared to other health care providers for the same services in the same market; (3) the transacting parties' health status adjusted total medical expense, including the transacting parties' health status adjusted total medical expense compared to that of similar health care providers; (4) the quality of the services provided by the transacting parties, including patient experience; (5) the transacting parties' cost and cost trends in comparison to total health care expenditures state wide; (6) the availability and accessibility of services similar to those provided by each transacting party, or proposed to be provided as a result of the transfer of ownership of a hospital within each transacting party's primary service areas and dispersed service areas; (7) the impact of the proposed transfer of ownership of the hospital on competing options

for the delivery of health care services within each transacting party's primary service area and dispersed service area including the impact on existing service providers; (8) the methods used by the transacting parties to attract patient volume and to recruit or acquire health care professionals or facilities; (9) the role of each transacting party in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within each transacting party's primary service area and dispersed service area; (10) the role of each transacting party in providing low margin or negative margin services within each transacting party's primary service area and dispersed service area; (11) consumer concerns, including, but not limited to, complaints or other allegations that a transacting party has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (12) any other factors that the **[**office**]** unit determines to be in the public interest.

(e) Not later than ninety days after the **[**office**]** unit determines that there is substantial compliance with any request for documents or information issued by the **[**office**]** unit in accordance with this section, or a later date set by mutual agreement of the **[**office**]** unit and the transacting parties, the **[**office**]** unit shall make factual findings and issue a preliminary report on the cost and market impact review. Such preliminary report shall include, but shall not be limited to, an indication as to whether a transacting party meets the following criteria: (1) Currently has or, following the proposed transfer of operations of the hospital, is likely to have a dominant market share for the services the transacting party provides; and (2) (A) currently charges or, following the proposed transfer of operations of the hospital, is likely to charge prices for services that are materially higher than the median prices charged by all other health care providers for the same services in the same market, or (B) currently has or, following the proposed transfer of operations of a hospital, is likely to have a health status adjusted total medical expense that is materially higher than the median total medical expense for all other health care providers for the same service in the same market.

(f) The transacting parties that are the subject of the cost and market impact review may respond in writing to the findings in the preliminary report issued in accordance with subsection (e) of this section not later than thirty days after the issuance of the preliminary report. Not later than sixty days after the issuance of the preliminary report, the **[**office**]** unit shall issue a final report of the cost and market impact review. The **[**office**]** unit shall refer to the Attorney General any final report on any proposed transfer of ownership that meets the criteria described in subsection (e) of this section.

(g) Nothing in this section shall prohibit a transfer of ownership of a hospital, provided any such proposed transfer shall not be completed (1) less than thirty days after the **[**office**]** unit has issued a final report on a cost and market impact review, if such review is required, or (2) while any action brought by the Attorney General pursuant to subsection (h) of this section is pending and before a final judgment on such action is issued by a court of competent jurisdiction.

(h) After the **[**office**]** unit refers a final report on a transfer of ownership of a hospital to the Attorney General under subsection (f) of this section, the Attorney General may: (1) Conduct an investigation to determine whether the transacting parties engaged, or, as a result of completing the transfer of ownership of the hospital, are expected to engage in unfair methods of competition, anti-competitive behavior or other conduct in violation of chapter 624 or 735a or any other state or federal law; and (2) if appropriate, take action under chapter 624 or 735a or any other state law to protect consumers in the health care market. The **[**office's**]** unit's final report may be evidence in any such action.

(i) For the purposes of this section, the provisions of chapter 735a may be directly enforced by the Attorney General. Nothing in this section shall be construed to modify, impair or supersede the operation of any state antitrust law or otherwise limit the authority of the Attorney General to (1) take any action against a transacting party as authorized by any law, or (2) protect consumers in the health care

market under any law. Notwithstanding subdivision (1) of subsection (a) of section 42-110c, the transacting parties shall be subject to chapter 735a.

(j) The **[**office**]** unit shall retain an independent consultant with expertise on the economic analysis of the health care market and health care costs and prices to conduct each cost and market impact review, as described in this section. The **[**office**]** unit shall submit bills for such services to the purchaser, as defined in subsection (d) of section 19a-639, as amended by this act. Such purchaser shall pay such bills not later than thirty days after receipt. Such bills shall not exceed two hundred thousand dollars per application. The provisions of chapter 57, sections 4-212 to 4-219, inclusive, and section 4e-19 shall not apply to any agreement executed pursuant to this subsection.

(k) Any employee of the **[**office**]** unit who directly oversees or assists in conducting a cost and market impact review shall not take part in factual deliberations or the issuance of a preliminary or final decision on the certificate of need application concerning the transfer of ownership of a hospital that is the subject of such cost and market impact review.

(l) The **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy shall adopt regulations, in accordance with the provisions of chapter 54, concerning cost and market impact reviews and to administer the provisions of this section. Such regulations shall include definitions of the following terms: "Dispersed service area", "health status adjusted total medical expense", "major service category", "relative prices", "total health care spending" and "health care services". The **[**commissioner**]** executive director may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the **[**commissioner**]** executive director publishes notice of intention to adopt the regulations on the **[**Department of Public Health's**]** office's Internet web site and the eRegulations System not later than twenty days after

implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Sec. 86. Section 19a-641 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

Any health care facility or institution and any state health care facility or institution aggrieved by any final decision of said **[**office**]** unit under the provisions of sections 19a-630 to 19a-639e, inclusive, as amended by this act, may appeal from such decision in accordance with the provisions of section 4-183, except venue shall be in the judicial district in which it is located. Such appeal shall have precedence in respect to order of trial over all other cases except writs of habeas corpus, actions brought by or on behalf of the state, including **[**informations**]** information on the relation of private individuals, and appeals from awards or decisions of workers' compensation commissioners.

Sec. 87. Section 19a-642 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

The Superior Court on application of the **[**office**]** unit or the Attorney General, may enforce, by appropriate decree or process, any provision of this chapter or any act or any order of the **[**office**]** unit rendered in pursuance of any statutory provision.

Sec. 88. Section 19a-643 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) The **[**Department of Public Health**]** Office of Health Strategy shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of sections 19a-630 to 19a-639e, inclusive, as amended by this act, and sections 19a-644 and 19a-645, as amended by this act, concerning the submission of data by health care facilities and institutions, including data on dealings between health care facilities and institutions and their affiliates, and, with regard to

requests or proposals pursuant to sections 19a-638 to 19a-639e, inclusive, as amended by this act, by state health care facilities and institutions, the ongoing inspections by the [office] unit of operating budgets that have been approved by the health care facilities and institutions, standard reporting forms and standard accounting procedures to be utilized by health care facilities and institutions and the transferability of line items in the approved operating budgets of the health care facilities and institutions, except that any health care facility or institution may transfer any amounts among items in its operating budget. All such transfers shall be reported to the [office within] unit not later than thirty days [of] after the transfer or transfers.

(b) The [Department of Public Health] Office of Health Strategy may adopt such regulations, in accordance with the provisions of chapter 54, as are necessary to implement this chapter.

Sec. 89. Section 19a-644 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) On or before February twenty-eighth annually, for the fiscal year ending on September thirtieth of the immediately preceding year, each short-term acute care general or children's hospital shall report to the [office] unit with respect to its operations in such fiscal year, in such form as the [office] unit may by regulation require. Such report shall include: (1) Salaries and fringe benefits for the ten highest paid hospital and health system employees; (2) the name of each joint venture, partnership, subsidiary and corporation related to the hospital; and (3) the salaries paid to hospital and health system employees by each such joint venture, partnership, subsidiary and related corporation and by the hospital to the employees of related corporations. For purposes of this subsection, "health system" has the same meaning as provided in section 33-182aa.

(b) The [Department of Public Health] Office of Health Strategy shall adopt regulations in accordance with chapter 54 to provide for the collection of data and information in addition to the annual report required in subsection (a) of this section. Such regulations shall

provide for the submission of information about the operations of the following entities: Persons or parent corporations that own or control the health care facility, institution or provider; corporations, including limited liability corporations, in which the health care facility, institution, provider, its parent, any type of affiliate or any combination thereof, owns more than an aggregate of fifty per cent of the stock or, in the case of nonstock corporations, is the sole member; and any partnerships in which the person, health care facility, institution, provider, its parent or an affiliate or any combination thereof, or any combination of health care providers or related persons, owns a greater than fifty per cent interest. For purposes of this **[**section**]** subsection, "affiliate" means any person that directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with any health care facility, institution, provider or person that is regulated in any way under this chapter. A person is deemed controlled by another person if the other person, or one of that other person's affiliates, officers, agents or management employees, acts as a general partner or manager of the person in question.

(c) Each nonprofit short-term acute care general or children's hospital shall include in the annual report required pursuant to subsection (a) of this section a report of all transfers of assets, transfers of operations or changes of control involving its clinical or nonclinical services or functions from such hospital to a person or entity organized or operated for profit.

(d) Each hospital that is a party to a transfer of ownership involving a hospital for which a certificate of need application was filed and approved pursuant to this chapter shall, during the fiscal year ending on September thirtieth of the immediately preceding year, include in the annual report required pursuant to subsection (a) of this section any salary, severance payment, stock offering or other financial gain realized by each officer, director, board member or senior manager of the hospital as a result of such transaction.

(e) The [office] unit shall require each hospital licensed by the Department of Public Health, that is not subject to the provisions of subsection (a) of this section, to report to said [office] unit on its operations in the preceding fiscal year by filing copies of the hospital's audited financial statements, except a health system, as defined in section 19a-508c, as amended by this act, may submit to the [office] unit one such report that includes the audited financial statements for each of its hospitals. Such report shall be due at the [office] unit on or before the close of business on the last business day of the fifth month following the month in which a hospital's fiscal year ends.

Sec. 90. Section 19a-645 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

A nonprofit hospital, licensed by the Department of Public Health, which provides lodging, care and treatment to members of the public, and which wishes to enlarge its public facilities by adding contiguous land and buildings thereon, if any, the title to which it cannot otherwise acquire, may prefer a complaint for the right to take such land to the superior court for the judicial district in which such land is located, provided such hospital shall have received the approval of the [Office of Health Care Access division] Health Systems Planning Unit of the [Department of Public Health] Office of Health Strategy in accordance with the provisions of this chapter. Said court shall appoint a committee of three disinterested persons, who, after examining the premises and hearing the parties, shall report to the court as to the necessity and propriety of such enlargement and as to the quantity, boundaries and value of the land and buildings thereon, if any, which they deem proper to be taken for such purpose and the damages resulting from such taking. If such committee reports that such enlargement is necessary and proper and the court accepts such report, the decision of said court thereon shall have the effect of a judgment and execution may be issued thereon accordingly, in favor of the person to whom damages may be assessed, for the amount thereof; and, on payment thereof, the title to the land and buildings thereon, if any, for such purpose shall be vested in the complainant, but such land

and buildings thereon, if any, shall not be taken until such damages are paid to such owner or deposited with said court, for such owner's use, within thirty days after such report is accepted. If such application is denied, the owner of the land shall recover costs of the applicant, to be taxed by said court, which may issue execution therefor. Land so taken shall be held by such hospital and used only for the public purpose stated in its complaint to the superior court. No land dedicated or otherwise reserved as open space or park land or for other recreational purposes and no land belonging to any town, city or borough shall be taken under the provisions of this section.

Sec. 91. Section 19a-646 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) As used in this section:

[(1) "Office" means the Office of Health Care Access division of the Department of Public Health;**]**

(1) "Unit" means the Health Systems Planning Unit within the Office of Health Strategy, established under section 19a-612, as amended by this act;

(2) "Fiscal year" means the hospital fiscal year, as used for purposes of this chapter, consisting of a twelve-month period commencing on October first and ending the following September thirtieth;

(3) "Hospital" means any short-term acute care general or children's hospital licensed by the Department of Public Health, including the John Dempsey Hospital of The University of Connecticut Health Center;

(4) "Payer" means any person, legal entity, governmental body or eligible organization that meets the definition of an eligible organization under 42 USC Section 1395mm (b) of the Social Security Act, or any combination thereof, except for Medicare and Medicaid which is or may become legally responsible, in whole or in part for the payment of services rendered to or on behalf of a patient by a hospital.

Payer also includes any legal entity whose membership includes one or more payers and any third-party payer; and

(5) "Prompt payment" means payment made for services to a hospital by mail or other means on or before the tenth business day after receipt of the bill by the payer.

(b) No hospital shall provide a discount or different rate or method of reimbursement from the filed rates or charges to any payer except as provided in this section.

(c) (1) Any payer may directly negotiate with a hospital for a different rate or method of reimbursement, or both, provided the charges and payments for the payer are on file at the hospital business office in accordance with this subsection. No discount agreement or agreement for a different rate or method of reimbursement, or both, shall be effective until a complete written agreement between the hospital and the payer is on file at the hospital. Each such agreement shall be available to the **[**office**]** unit for inspection or submission to the **[**office**]** unit upon request, for at least three years after the close of the applicable fiscal year.

(2) The charges and payments for each payer receiving a discount shall be accumulated by the hospital for each payer and reported as required by the **[**office**]** unit.

(3) A full written copy of each agreement executed pursuant to this subsection shall be on file in the hospital business office within twenty-four hours of execution.

(d) A payer may negotiate with a hospital to obtain a discount on rates or charges for prompt payment.

(e) A payer may also negotiate for and may receive a discount for the provision of the following administrative services: (1) A system which permits the hospital to bill the payer through either a computer-processed or machine-readable or similar billing procedure; (2) a system which enables the hospital to verify coverage of a patient by

the payer at the time the service is provided; and (3) a guarantee of payment within the scope of the agreement between the patient and the third-party payer for service to the patient prior to the provision of that service.

(f) No hospital may require a payer to negotiate for another element or any combination of the above elements of a discount, as established in subsections (d) and (e) of this section, in order to negotiate for or obtain a discount for any single element. No hospital may require a payer to negotiate a discount for all patients covered by such payer in order to negotiate a discount for any patient or group of patients covered by such payer.

(g) Any hospital which agrees to provide a discount to a payer under subsection (d) or (e) of this section shall file a copy of the agreement in the hospital's business office and shall provide the same discount to any other payer who agrees to make prompt payment or provide administrative services similar to that contained in the agreement. Each agreement filed shall specify on its face that it was executed and filed pursuant to this subsection.

(h) (1) Nothing in this section shall be construed to require payment by any payer or purchaser, under any program or contract for payment or reimbursement of expenses for health care services, for: (A) Services not covered under such program or contract; or (B) that portion of any charge for services furnished by a hospital that exceeds the amount covered by such program or contract.

(2) Nothing in this section shall be construed to supersede or modify any provision of such program or contract that requires payment of a copayment, deductible or enrollment fee or that imposes any similar requirement.

(i) A hospital which has established a program approved by the **[**office**]** unit with one or more banks for the purpose of reducing the hospital's bad debt load, may reduce its published charges for that portion of a patient's bill for services which a payer who is a private

individual is or may become legally responsible for, after all other insurers or third-party payers have been assessed their full charges provided (1) prior to the rendering of such services, the hospital and the individual payer or parent or guardian or custodian have agreed in writing that after receipt of any insurer or third-party payment paid in accordance with the full hospital charges the remaining payment due from the private individual for such reduced charges shall be made in whole or in part from the balance on deposit in a bank account which has been established by or on behalf of such individual patient, and (2) such payment is made from such account. Nothing in this section shall relieve a patient or legally liable person from being responsible for the full amount of any underpayment of the hospital's authorized charges excluding any discount under this section, by a patient's insurer or any other third-party payer for that insurer's or third-party payer's portion of the bill. Any reduction in charges granted to an individual or parent or guardian or custodian under this subsection shall be reported to the **[**office**]** unit as a contractual allowance. For purposes of this **[**section**]** subsection "private individual" shall include a patient's parent, legal guardian or legal custodian but shall not include an insurer or third-party payer.

Sec. 92. Section 19a-649 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) The **[**office**]** unit shall review annually the level of uncompensated care provided by each hospital to the indigent. Each hospital shall file annually with the **[**office**]** unit its policies regarding the provision of charity care and reduced cost services to the indigent, excluding medical assistance recipients, and its debt collection practices. A hospital shall file its audited financial statements not later than February twenty-eighth of each year, except a health system, as defined in section 19a-508c, as amended by this act, may file one such statement that includes the audited financial statements for each hospital within the health system. Not later than March thirty-first of each year, the hospital shall file a verification of the hospital's net revenue for the most recently completed fiscal year in a format

prescribed by the [office] unit.

(b) Each hospital shall annually report, along with data submitted pursuant to subsection (a) of this section, (1) the number of applicants for charity care and reduced cost services, (2) the number of approved applicants, and (3) the total and average charges and costs of the amount of charity care and reduced cost services provided.

(c) Each hospital recognized as a nonprofit organization under Section 501(c)(3) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, shall, along with data submitted annually pursuant to subsection (a) of this section, submit to the [office] unit (1) a complete copy of such hospital's most-recently completed Internal Revenue Service form 990, including all parts and schedules; and (2) in the form and manner prescribed by the [office] unit, data compiled to prepare such hospital's community health needs assessment, as required pursuant to Section 501(r) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, provided such copy and data submitted pursuant to this subsection shall not include: (A) Individual patient information, including, but not limited to, patient-identifiable information; (B) information that is not owned or controlled by such hospital; (C) information that such hospital is contractually required to keep confidential or that is prohibited from disclosure by a data use agreement; or (D) information concerning research on human subjects as described in section 45 CFR 46.101 et seq., as amended from time to time.

Sec. 93. Section 19a-653 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) Any person or health care facility or institution that is required to file a certificate of need for any of the activities described in section 19a-638, as amended by this act, and any person or health care facility or institution that is required to file data or information under any public or special act or under this chapter or sections 19a-486 to 19a-

486h, inclusive, as amended by this act, or any regulation adopted or order issued under this chapter or said sections, which wilfully fails to seek certificate of need approval for any of the activities described in section 19a-638, as amended by this act, or to so file within prescribed time periods, shall be subject to a civil penalty of up to one thousand dollars a day for each day such person or health care facility or institution conducts any of the described activities without certificate of need approval as required by section 19a-638, as amended by this act, or for each day such information is missing, incomplete or inaccurate. Any civil penalty authorized by this section shall be imposed by the **[**Department of Public Health**]** Office of Health Strategy in accordance with subsections (b) to (e), inclusive, of this section.

(b) If the **[**Department of Public Health**]** Office of Health Strategy has reason to believe that a violation has occurred for which a civil penalty is authorized by subsection (a) of this section or subsection (e) of section 19a-632, as amended by this act, it shall notify the person or health care facility or institution by first-class mail or personal service. The notice shall include: (1) A reference to the sections of the statute or regulation involved; (2) a short and plain statement of the matters asserted or charged; (3) a statement of the amount of the civil penalty or penalties to be imposed; (4) the initial date of the imposition of the penalty; and (5) a statement of the party's right to a hearing.

(c) The person or health care facility or institution to whom the notice is addressed shall have fifteen business days from the date of mailing of the notice to make written application to the **[**office**]** unit to request (1) a hearing to contest the imposition of the penalty, or (2) an extension of time to file the required data. A failure to make a timely request for a hearing or an extension of time to file the required data or a denial of a request for an extension of time shall result in a final order for the imposition of the penalty. All hearings under this section shall be conducted pursuant to sections 4-176e to 4-184, inclusive. The **[**Department of Public Health**]** Office of Health Strategy may grant an extension of time for filing the required data or mitigate or waive the

penalty upon such terms and conditions as, in its discretion, it deems proper or necessary upon consideration of any extenuating factors or circumstances.

(d) A final order of the **[**Department of Public Health**]** Office of Health Strategy assessing a civil penalty shall be subject to appeal as set forth in section 4-183 after a hearing before the **[**office**]** unit pursuant to subsection (c) of this section, except that any such appeal shall be taken to the superior court for the judicial district of New Britain. Such final order shall not be subject to appeal under any other provision of the general statutes. No challenge to any such final order shall be allowed as to any issue which could have been raised by an appeal of an earlier order, denial or other final decision by the **[**Department of Public Health**]** office.

(e) If any person or health care facility or institution fails to pay any civil penalty under this section, after the assessment of such penalty has become final the amount of such penalty may be deducted from payments to such person or health care facility or institution from the Medicaid account.

Sec. 94. Section 19a-654 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) As used in this section:

(1) "Patient-identifiable data" means any information that identifies or may reasonably be used as a basis to identify an individual patient; and

(2) "De-identified patient data" means any information that meets the requirements for de-identification of protected health information as set forth in 45 CFR 164.514.

(b) Each short-term acute care general or children's hospital shall submit patient-identifiable inpatient discharge data and emergency department data to the **[**Office of Health Care Access division**]** Health Systems Planning Unit of the **[**Department of Public Health**]** Office of

Health Strategy to fulfill the responsibilities of the [office] unit. Such data shall include data taken from patient medical record abstracts and bills. The [office] unit shall specify the timing and format of such submissions. Data submitted pursuant to this section may be submitted through a contractual arrangement with an intermediary and such contractual arrangement shall (1) comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 P.L. 104-191 (HIPAA), and (2) ensure that such submission of data is timely and accurate. The [office] unit may conduct an audit of the data submitted through such intermediary in order to verify its accuracy.

(c) An outpatient surgical facility, as defined in section 19a-493b, as amended by this act, a short-term acute care general or children's hospital, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care hospital shall submit to the [office] unit the data identified in subsection (c) of section 19a-634, as amended by this act. The [office] unit shall convene a working group consisting of representatives of outpatient surgical facilities, hospitals and other individuals necessary to develop recommendations that address current obstacles to, and proposed requirements for, patient-identifiable data reporting in the outpatient setting. On or before February 1, 2012, the working group shall report, in accordance with the provisions of section 11-4a, on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance and real estate. Additional reporting of outpatient data as the [office] unit deems necessary shall begin not later than July 1, 2015. On or before July 1, [2012] 2018, and annually thereafter, the Connecticut Association of Ambulatory Surgery Centers shall provide a progress report to the [Department of Public Health] Office of Health Strategy, until such time as all ambulatory surgery centers are in full compliance with the implementation of systems that allow for the reporting of outpatient data as required by the [commissioner] executive director. Until such additional reporting requirements take effect on July 1, 2015, the department may work with the Connecticut Association of Ambulatory Surgery Centers and

the Connecticut Hospital Association on specific data reporting initiatives provided that no penalties shall be assessed under this chapter or any other provision of law with respect to the failure to submit such data.

(d) Except as provided in this subsection, patient-identifiable data received by the **[**office**]** unit shall be kept confidential and shall not be considered public records or files subject to disclosure under the Freedom of Information Act, as defined in section 1-200. The **[**office**]** unit may release de-identified patient data or aggregate patient data to the public in a manner consistent with the provisions of 45 CFR 164.514. Any de-identified patient data released by the **[**office**]** unit shall exclude provider, physician and payer organization names or codes and shall be kept confidential by the recipient. The **[**office**]** unit may release patient-identifiable data (1) for medical and scientific research as provided for in section 19a-25-3 of the regulations of Connecticut state agencies, and (2) to (A) a state agency for the purpose of improving health care service delivery, (B) a federal agency or the office of the Attorney General for the purpose of investigating hospital mergers and acquisitions, or (C) another state's health data collection agency with which the **[**office**]** unit has entered into a reciprocal data-sharing agreement for the purpose of certificate of need review or evaluation of health care services, upon receipt of a request from such agency, provided, prior to the release of such patient-identifiable data, such agency enters into a written agreement with the **[**office**]** unit pursuant to which such agency agrees to protect the confidentiality of such patient-identifiable data and not to use such patient-identifiable data as a basis for any decision concerning a patient. No individual or entity receiving patient-identifiable data may release such data in any manner that may result in an individual patient, physician, provider or payer being identified. The **[**office**]** unit shall impose a reasonable, cost-based fee for any patient data provided to a nongovernmental entity.

(e) Not later than October 1, **[**2011**]** 2018, the **[**Office of Health Care Access**]** Health Systems Planning Unit shall enter into a memorandum

of understanding with the Comptroller that shall permit the Comptroller to access the data set forth in subsections (b) and (c) of this section, provided the Comptroller agrees, in writing, to keep individual patient and provider data identified by proper name or personal identification code and submitted pursuant to this section confidential.

(f) The **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this section.

(g) The duties assigned to the **[**Department of Public Health**]** Office of Health Strategy under the provisions of this section shall be implemented within available appropriations.

Sec. 95. Section 19a-659 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

As used in **[**this chapter**]** sections 19a-644, as amended by this act, 19a-649, as amended by this act, 19a-670, as amended by this act, and 19a-676, as amended by this act, unless the context otherwise requires:

[(1) "Office" means the Office of Health Care Access division of the Department of Public Health;**]**

(1) "Unit" means the Health Systems Planning Unit within the Office of Health Strategy, established under section 19a-612, as amended by this act;

(2) "Hospital" means any hospital licensed as a short-term acute care general or children's hospital by the Department of Public Health, including John Dempsey Hospital of The University of Connecticut Health Center;

(3) "Fiscal year" means the hospital fiscal year consisting of a twelve-month period commencing on October first and ending the following September thirtieth;

(4) "Affiliate" means a person, entity or organization controlling, controlled by, or under common control with another person, entity or organization;

(5) "Uncompensated care" means the total amount of charity care and bad debts determined by using the hospital's published charges and consistent with the hospital's policies regarding charity care and bad debts which are on file at the **[**office**]** unit;

(6) "Medical assistance" means (A) the programs for medical assistance provided under the Medicaid program, including HUSKY A, or (B) any other state-funded medical assistance program, including HUSKY B;

(7) "CHAMPUS" or "TriCare" means the federal Civilian Health and Medical Program of the Uniformed Services, as defined in 10 USC 1072(4), as from time to time amended;

(8) "Primary payer" means the payer responsible for the highest percentage of the charges for a patient's inpatient or outpatient hospital services;

(9) "Case mix index" means the arithmetic mean of the Medicare diagnosis related group case weights assigned to each inpatient discharge for a specific hospital during a given fiscal year. The case mix index shall be calculated by dividing the hospital's total case mix adjusted discharges by the hospital's actual number of discharges for the fiscal year. The total case mix adjusted discharges shall be calculated by (A) multiplying the number of discharges in each diagnosis-related group by the Medicare weights in effect for that same diagnosis-related group and fiscal year, and (B) then totaling the resulting products for all diagnosis-related groups;

(10) "Contractual allowances" means the difference between hospital published charges and payments generated by negotiated agreements for a different or discounted rate or method of payment;

(11) "Medical assistance underpayment" means the amount

calculated by dividing the total net revenue by the total gross revenue, and then multiplying the quotient by the total medical assistance charges, and then subtracting medical assistance payments from the product;

(12) "Other allowances" means the amount of any difference between charges for employee self-insurance and related expenses determined using the hospital's overall relationship of costs to charges;

(13) "Gross revenue" means the total gross patient charges for all patient services provided by a hospital; and

(14) "Net revenue" means total gross revenue less contractual allowance, less the difference between government charges and government payments, less uncompensated care and other allowances.

Sec. 96. Section 19a-670 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

The **[**office**]** unit shall, by September first of each year, report the results of the **[**office's**]** unit's review of the hospitals' annual and twelve-month filings under sections 19a-644, as amended by this act, 19a-649, as amended by this act, and 19a-676, as amended by this act, for the previous hospital fiscal year to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The report shall include information concerning the financial stability of hospitals in a competitive market.

Sec. 97. Subdivision (1) of subsection (a) of section 19a-673 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(1) "Cost of providing services" means a hospital's published charges at the time of billing, multiplied by the hospital's most recent relationship of costs to charges as taken from the hospital's most recently available annual financial filing with the **[**office**]** unit.

Sec. 98. Section 19a-673a of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2018*):

The **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy shall adopt regulations, in accordance with chapter 54, to establish uniform debt collection standards for hospitals.

Sec. 99. Section 19a-673c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

On or before March 1, 2004, and annually thereafter, each hospital shall file with the **[**office**]** unit a debt collection report that includes (1) whether the hospital uses a collection agent, as defined in section 19a-509b, as amended by this act, to assist with debt collection, (2) the name of any collection agent used, (3) the hospital's processes and policies for assigning a debt to a collection agent and for compensating such collection agent for services rendered, and (4) the recovery rate on accounts assigned to collection agents, exclusive of Medicare accounts, in the most recent hospital fiscal year.

Sec. 100. Section 19a-676 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

On or before March thirty-first of each year, for the preceding fiscal year, each hospital shall submit to the **[**office**]** unit, in the form and manner prescribed by the **[**office**]** unit, the data specified in regulations adopted by the **[**commissioner**]** executive director in accordance with chapter 54, the hospital's verification of net revenue required under section 19a-649, as amended by this act, and any other data required by the **[**office**]** unit, including hospital budget system data for the hospital's twelve months' actual filing requirements.

Sec. 101. Section 19a-681 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) For purposes of this section: (1) "Detailed patient bill" means a patient billing statement that includes, in each line item, the hospital's current pricemaster code, a description of the charge and the billed amount; and (2) "pricemaster" means a detailed schedule of hospital

charges.

(b) Each hospital shall file with the **[**office**]** unit its current pricemaster which shall include each charge in its detailed schedule of charges.

(c) Upon the request of the **[**Department of Public Health**]** Office of Health Strategy, established under section 19a-754a, as amended by this act, or a patient, a hospital shall provide to the **[**department**]** office or the patient a detailed patient bill. If the billing detail by line item on a detailed patient bill does not agree with the detailed schedule of charges on file with the **[**office**]** unit for the date of service specified on the bill, the hospital shall be subject to a civil penalty of five hundred dollars per occurrence payable to the state not later than fourteen days after the date of notification. The penalty shall be imposed in accordance with section 19a-653, as amended by this act. The **[**office**]** unit may issue an order requiring such hospital, not later than fourteen days after the date of notification of an overcharge to a patient, to adjust the bill to be consistent with the detailed schedule of charges on file with the **[**office**]** unit for the date of service specified on the detailed patient bill.

Sec. 102. Section 19a-486 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

For purposes of sections 19a-486 to 19a-486h, inclusive, as amended by this act:

(1) "Nonprofit hospital" means a nonprofit entity licensed as a hospital pursuant to this chapter and any entity affiliated with such a hospital through governance or membership, including, but not limited to, a holding company or subsidiary.

(2) "Purchaser" means a person acquiring any assets of a nonprofit hospital through a transfer.

(3) "Person" means any individual, firm, partnership, corporation, limited liability company, association or other entity.

(4) "Transfer" means to sell, transfer, lease, exchange, option, convey, give or otherwise dispose of or transfer control over, including, but not limited to, transfer by way of merger or joint venture not in the ordinary course of business.

(5) "Control" has the meaning assigned to it in section 36b-41.

(6) **[**"Commissioner" means the Commissioner of Public Health or the commissioner's designee.**]** "Executive director" means the executive director of the Office of Health Strategy, established under section 19a-754a, as amended by this act, or the executive director's designee.

Sec. 103. Section 19a-486a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) No nonprofit hospital shall enter into an agreement to transfer a material amount of its assets or operations or a change in control of operations to a person that is organized or operated for profit without first having received approval of the agreement by the **[**commissioner**]** executive director and the Attorney General pursuant to sections 19a-486 to 19a-486h, inclusive, as amended by this act, and pursuant to the Attorney General's authority under section 3-125. Any such agreement without the approval required by sections 19a-486 to 19a-486h, inclusive, as amended by this act, shall be void.

(b) Prior to any transaction described in subsection (a) of this section, the nonprofit hospital and the purchaser shall concurrently submit a certificate of need determination letter as described in subsection (c) of section 19a-638, as amended by this act, to the **[**commissioner**]** executive director and the Attorney General by serving it on them by certified mail, return receipt requested, or delivering it by hand to each office. The certificate of need determination letter shall contain: (1) The name and address of the nonprofit hospital; (2) the name and address of the purchaser; (3) a brief description of the terms of the proposed agreement; and (4) the estimated capital expenditure, cost or value associated with the proposed agreement. The certificate of need determination letter shall be subject to disclosure pursuant to

section 1-210, as amended by this act.

(c) Not later than thirty days after receipt of the certificate of need determination letter by the [commissioner] executive director and the Attorney General, the purchaser and the nonprofit hospital shall hold a hearing on the contents of the certificate of need determination letter in the municipality in which the new hospital is proposed to be located. The nonprofit hospital shall provide not less than two weeks' advance notice of the hearing to the public by publication in a newspaper having a substantial circulation in the affected community for not less than three consecutive days. Such notice shall contain substantially the same information as in the certificate of need determination letter. The purchaser and the nonprofit hospital shall record and transcribe the hearing and make such recording or transcription available to the [commissioner] executive director, the Attorney General or members of the public upon request. A public hearing held in accordance with the provisions of section 19a-639a, as amended by this act, shall satisfy the requirements of this subsection.

(d) The [commissioner] executive director and the Attorney General shall review the certificate of need determination letter. The Attorney General shall determine whether the agreement requires approval pursuant to this chapter. If such approval is required, the [commissioner] executive director and the Attorney General shall transmit to the purchaser and the nonprofit hospital an application form for approval pursuant to this chapter, unless the [commissioner] executive director refuses to accept a filed or submitted certificate of need determination letter. Such application form shall require the following information: (1) The name and address of the nonprofit hospital; (2) the name and address of the purchaser; (3) a description of the terms of the proposed agreement; (4) copies of all contracts, agreements and memoranda of understanding relating to the proposed agreement; (5) a fairness evaluation by an independent person who is an expert in such agreements, that includes an analysis of each of the criteria set forth in section 19a-486c; (6) documentation that the nonprofit hospital exercised the due diligence required by subdivision

(2) of subsection (a) of section 19a-486c, including disclosure of the terms of any other offers to transfer assets or operations or change control of operations received by the nonprofit hospital and the reason for rejection of such offers; and (7) such other information as the **[**commissioner**]** executive director or the Attorney General deem necessary to their review pursuant to the provisions of sections 19a-486 to 19a-486f, inclusive, as amended by this act, and chapter 368z. The application shall be subject to disclosure pursuant to section 1-210, as amended by this act.

(e) No later than sixty days after the date of mailing of the application form, the nonprofit hospital and the purchaser shall concurrently file an application with the **[**commissioner**]** executive director and the Attorney General containing all the required information. The **[**commissioner**]** executive director and the Attorney General shall review the application and determine whether the application is complete. The **[**commissioner**]** executive director and the Attorney General shall, no later than twenty days after the date of their receipt of the application, provide written notice to the nonprofit hospital and the purchaser of any deficiencies in the application. Such application shall not be deemed complete until such deficiencies are corrected.

(f) No later than twenty-five days after the date of their receipt of the completed application under this section, the **[**commissioner**]** executive director and the Attorney General shall jointly publish a summary of such agreement in a newspaper of general circulation where the nonprofit hospital is located.

(g) Any person may seek to intervene in the proceedings under section 19a-486e, as amended by this act, in the same manner as provided in section 4-177a.

Sec. 104. Section 19a-486b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) Not later than one hundred twenty days after the date of receipt

of the completed application pursuant to subsection (e) of section 19a-486a, as amended by this act, the Attorney General and the [commissioner] executive director shall approve the application, with or without modification, or deny the application. The [commissioner] executive director shall also determine, in accordance with the provisions of chapter 368z, whether to approve, with or without modification, or deny the application for a certificate of need that is part of the completed application. Notwithstanding the provisions of section 19a-639a, as amended by this act, the [commissioner] executive director shall complete the decision on the application for a certificate of need within the same time period as the completed application. Such one-hundred-twenty-day period may be extended by (1) agreement of the Attorney General, the [commissioner] executive director, the nonprofit hospital and the purchaser, or (2) the [commissioner] executive director for an additional one hundred twenty days pending completion of a cost and market impact review conducted pursuant to section 19a-639f, as amended by this act. If the Attorney General initiates a proceeding to enforce a subpoena pursuant to section 19a-486c or 19a-486d, as amended by this act, the one-hundred-twenty-day period shall be tolled until the final court decision on the last pending enforcement proceeding, including any appeal or time for the filing of such appeal. Unless the one-hundred-twenty-day period is extended pursuant to this section, if the [commissioner] executive director and Attorney General fail to take action on an agreement prior to the one hundred twenty-first day after the date of the filing of the completed application, the application shall be deemed approved.

(b) The [commissioner] executive director and the Attorney General may place any conditions on the approval of an application that relate to the purposes of sections 19a-486a to 19a-486h, inclusive, as amended by this act. In placing any such conditions the [commissioner] executive director shall follow the guidelines and criteria described in subdivision (4) of subsection (d) of section 19a-639, as amended by this act. Any such conditions may be in addition to any conditions placed by the [commissioner] executive director pursuant to subdivision (4) of

subsection (d) of section 19a-639, as amended by this act.

Sec. 105. Section 19a-486d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) The **[**commissioner**]** executive director shall deny an application filed pursuant to subsection (d) of section 19a-486a, as amended by this act, unless the **[**commissioner**]** executive director finds that: (1) In a situation where the asset or operation to be transferred provides or has provided health care services to the uninsured or underinsured, the purchaser has made a commitment to provide health care to the uninsured and the underinsured; (2) in a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or an entity related to the purchaser safeguard procedures are in place to avoid a conflict of interest in patient referral; and (3) certificate of need authorization is justified in accordance with chapter 368z. The **[**commissioner**]** executive director may contract with any person, including, but not limited to, financial or actuarial experts or consultants, or legal experts with the approval of the Attorney General, to assist in reviewing the completed application. The **[**commissioner**]** executive director shall submit any bills for such contracts to the purchaser. Such bills shall not exceed one hundred fifty thousand dollars. The purchaser shall pay such bills no later than thirty days after the date of receipt of such bills.

(b) The **[**commissioner**]** executive director may, during the course of a review required by this section: (1) Issue in writing and cause to be served upon any person, by subpoena, a demand that such person appear before the **[**commissioner**]** executive director and give testimony or produce documents as to any matters relevant to the scope of the review; and (2) issue written interrogatories, to be answered under oath, as to any matters relevant to the scope of the review and prescribing a return date that would allow a reasonable time to respond. If any person fails to comply with the provisions of this subsection, the **[**commissioner**]** executive director, through the Attorney General, may apply to the superior court for the judicial

district of Hartford seeking enforcement of such subpoena. The superior court may, upon notice to such person, issue and cause to be served an order requiring compliance. Service of subpoenas ad testificandum, subpoenas duces tecum, notices of deposition and written interrogatories as provided in this subsection may be made by personal service at the usual place of abode or by certified mail, return receipt requested, addressed to the person to be served at such person's principal place of business within or without this state or such person's residence.

Sec. 106. Section 19a-486e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

Prior to making any decision to approve, with or without modification, or deny any application filed pursuant to subsection (d) of section 19a-486a, as amended by this act, the Attorney General and the **[**commissioner**]** executive director shall jointly conduct one or more public hearings, one of which shall be in the primary service area of the nonprofit hospital. At least fourteen days before conducting the public hearing, the Attorney General and the **[**commissioner**]** executive director shall provide notice of the time and place of the hearing through publication in one or more newspapers of general circulation in the affected community.

Sec. 107. Section 19a-486f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

If the **[**commissioner**]** executive director or the Attorney General denies an application filed pursuant to subsection (d) of section 19a-486a, as amended by this act, or approves it with modification, the nonprofit hospital or the purchaser may appeal such decision in the same manner as provided in section 4-183, provided that nothing in sections 19a-486 to 19a-486f, inclusive, as amended by this act, shall be construed to apply the provisions of chapter 54 to the proceedings of the Attorney General.

Sec. 108. Section 19a-486g of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2018*):

The Commissioner of Public Health shall refuse to issue a license to, or if issued shall suspend or revoke the license of, a hospital if the commissioner finds, after a hearing and opportunity to be heard, that:

(1) There was a transaction described in section 19a-486a, as amended by this act, that occurred without the approval of the **[**commissioner**]** executive director, if such approval was required by sections 19a-486 to 19a-486h, inclusive, as amended by this act;

(2) There was a transaction described in section 19a-486a, as amended by this act, without the approval of the Attorney General, if such approval was required by sections 19a-486 to 19a-486h, inclusive, as amended by this act, and the Attorney General certifies to the **[**Commissioner of Public Health**]** executive director that such transaction involved a material amount of the nonprofit hospital's assets or operations or a change in control of operations; or

(3) The hospital is not complying with the terms of an agreement approved by the Attorney General and **[**commissioner**]** executive director pursuant to sections 19a-486 to 19a-486h, inclusive, as amended by this act.

Sec. 109. Section 19a-486h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

Nothing in sections 19a-486 to 19a-486h, inclusive, as amended by this act, shall be construed to limit: (1) The common law or statutory authority of the Attorney General; (2) the statutory authority of the Commissioner of Public Health including, but not limited to, licensing; **[**and**]** (3) the statutory authority of the executive director of the Office of Health Strategy, including, but not limited to, certificate of need authority; or **[**(3)**]** (4) the application of the doctrine of cy pres or approximation.

Sec. 110. Subsections (d) to (i), inclusive, of section 19a-486i of the 2018 supplement to the general statutes are repealed and the following

is substituted in lieu thereof (*Effective July 1, 2018*):

(d) (1) The written notice required under subsection (c) of this section shall identify each party to the transaction and describe the material change as of the date of such notice to the business or corporate structure of the group practice, including: (A) A description of the nature of the proposed relationship among the parties to the proposed transaction; (B) the names and specialties of each physician that is a member of the group practice that is the subject of the proposed transaction and who will practice medicine with the resulting group practice, hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by, or otherwise affiliated with such hospital or hospital system following the effective date of the transaction; (C) the names of the business entities that are to provide services following the effective date of the transaction; (D) the address for each location where such services are to be provided; (E) a description of the services to be provided at each such location; and (F) the primary service area to be served by each such location.

(2) Not later than thirty days after the effective date of any transaction described in subsection (c) of this section, the parties to the transaction shall submit written notice to the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy. Such written notice shall include, but need not be limited to, the same information described in subdivision (1) of this subsection. The **[**commissioner**]** executive director shall post a link to such notice on the **[**Department of Public Health's**]** Office of Health Strategy's Internet web site.

(e) Not less than thirty days prior to the effective date of any transaction that results in an affiliation between one hospital or hospital system and another hospital or hospital system, the parties to the affiliation shall submit written notice to the Attorney General of such affiliation. Such written notice shall identify each party to the affiliation and describe the affiliation as of the date of such notice,

including: (1) A description of the nature of the proposed relationship among the parties to the affiliation; (2) the names of the business entities that are to provide services following the effective date of the affiliation; (3) the address for each location where such services are to be provided; (4) a description of the services to be provided at each such location; and (5) the primary service area to be served by each such location.

(f) Written information submitted to the Attorney General pursuant to subsections (b) to (e), inclusive, of this section shall be maintained and used by the Attorney General in the same manner as provided in section 35-42.

(g) Not later than January 15, 2018, and annually thereafter, each hospital and hospital system shall file with the Attorney General and the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy a written report describing the activities of the group practices owned or affiliated with such hospital or hospital system. Such report shall include, for each such group practice: (1) A description of the nature of the relationship between the hospital or hospital system and the group practice; (2) the names and specialties of each physician practicing medicine with the group practice; (3) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

(h) Not later than January 15, 2018, and annually thereafter, each group practice comprised of thirty or more physicians that is not the subject of a report filed under subsection (g) of this section shall file with the Attorney General and the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy a written report concerning the group practice. Such report shall include, for each such group practice: (1) The names and specialties of each physician practicing medicine with the group practice; (2) the names of the business entities that provide services as part of the group practice and

the address for each location where such services are provided; (3) a description of the services provided at each such location; and (4) the primary service area served by each such location.

(i) Not later than January 15, 2018, and annually thereafter, each hospital and hospital system shall file with the Attorney General and the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy a written report describing each affiliation with another hospital or hospital system. Such report shall include: (1) The name and address of each party to the affiliation; (2) a description of the nature of the relationship among the parties to the affiliation; (3) the names of the business entities that provide services as part of the affiliation and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

Sec. 111. Subsections (j) to (m), inclusive, of section 19a-508c of the 2018 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(j) A hospital-based facility shall, when scheduling services for which a facility fee may be charged, inform the patient (1) that the hospital-based facility is part of a hospital or health system, (2) of the name of the hospital or health system, (3) that the hospital or health system may charge a facility fee in addition to and separate from the professional fee charged by the provider, and (4) of the telephone number the patient may call for additional information regarding such patient's potential financial liability.

(k) (1) On and after January 1, 2016, if any transaction, as described in subsection (c) of section 19a-486i, as amended by this act, results in the establishment of a hospital-based facility at which facility fees will likely be billed, the hospital or health system, that is the purchaser in such transaction shall, not later than thirty days after such transaction, provide written notice, by first class mail, of the transaction to each patient served within the previous three years by the health care facility that has been purchased as part of such transaction.

(2) Such notice shall include the following information:

(A) A statement that the health care facility is now a hospital-based facility and is part of a hospital or health system;

(B) The name, business address and phone number of the hospital or health system that is the purchaser of the health care facility;

(C) A statement that the hospital-based facility bills, or is likely to bill, patients a facility fee that may be in addition to, and separate from, any professional fee billed by a health care provider at the hospital-based facility;

(D) (i) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (ii) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility;

(E) The estimated amount or range of amounts the hospital-based facility may bill for a facility fee or an example of the average facility fee billed at such hospital-based facility for the most common services provided at such hospital-based facility; and

(F) A statement that, prior to seeking services at such hospital-based facility, a patient covered by a health insurance policy should contact the patient's health insurer for additional information regarding the hospital-based facility fees, including the patient's potential financial liability, if any, for such fees.

(3) A copy of the written notice provided to patients in accordance with this subsection shall be filed with the **[**Office of Health Care Access**]** Health Systems Planning Unit of the Office of Health Strategy, established under section 19a-612, as amended by this act. Said **[**office**]** unit shall post a link to such notice on its Internet web site.

(4) A hospital, health system or hospital-based facility shall not collect a facility fee for services provided at a hospital-based facility

that is subject to the provisions of this subsection from the date of the transaction until at least thirty days after the written notice required pursuant to this subsection is mailed to the patient or a copy of such notice is filed with the **[**Office of Health Care Access**]** Health Systems Planning Unit, whichever is later. A violation of this subsection shall be considered an unfair trade practice pursuant to section 42-110b.

(l) Notwithstanding the provisions of this section, on and after January 1, 2017, no hospital, health system or hospital-based facility shall collect a facility fee for (1) outpatient health care services that use a current procedural terminology evaluation and management code and are provided at a hospital-based facility, other than a hospital emergency department, located off-site from a hospital campus, or (2) outpatient health care services, other than those provided in an emergency department located off-site from a hospital campus, received by a patient who is uninsured of more than the Medicare rate. Notwithstanding the provisions of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of this section, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the date of expiration of such contract. A violation of this subsection shall be considered an unfair trade practice pursuant to chapter 735a.

(m) (1) Each hospital and health system shall report not later than July 1, 2016, and annually thereafter to the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy concerning facility fees charged or billed during the preceding calendar year. Such report shall include (A) the name and location of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility by Medicare, Medicaid or under private insurance policies, (D) for each facility, the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total

amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a description of the ten procedures or services that generated the greatest amount of facility fee revenue and, for each such procedure or service, the total amount of revenue received by the hospital or health system derived from facility fees, and (G) the top ten procedures for which facility fees are charged based on patient volume. For purposes of this subsection, "facility" means a hospital-based facility that is located outside a hospital campus.

(2) The **[**commissioner**]** executive director shall publish the information reported pursuant to subdivision (1) of this subsection, or post a link to such information, on the Internet web site of the Office of Health **[**Care Access**]** Strategy.

Sec. 112. Subsections (c) to (f), inclusive, of section 19a-509b of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(c) Each hospital that holds or administers one or more hospital bed funds shall make available in a place and manner allowing individual members of the public to easily obtain it, a one-page summary in English and Spanish describing hospital bed funds and how to apply for them. The summary shall also describe any other policies regarding the provision of charity care and reduced cost services for the indigent as reported by the hospital to the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy pursuant to section 19a-649, as amended by this act, and shall clearly distinguish hospital bed funds from other sources of financial assistance. The summary shall include notification that the patient is entitled to reapply upon rejection, and that additional funds may become available on an annual basis. The summary shall be available in the patient admissions office, emergency room, social services department and patient accounts or billing office, and from any collection agent. If during the admission process or during its review of the financial resources of the patient, the hospital

reasonably believes the patient will have limited funds to pay for any portion of the patient's hospitalization not covered by insurance, the hospital shall provide the summary to each such patient.

(d) Each hospital which holds or administers one or more hospital bed funds shall require its collection agents to include a summary as provided in subsection (c) of this section in all bills and collection notices sent by such collection agents.

(e) Applicants for assistance from hospital bed funds shall be notified in writing of any award or any rejection and the reason for such rejection. Patients who cannot pay any outstanding medical bill at the hospital shall be allowed to apply or reapply for hospital bed funds.

(f) Each hospital which holds or administers one or more hospital bed funds shall maintain and annually compile, at the end of the fiscal year of the hospital, the following information: (1) The number of applications for hospital bed funds; (2) the number of patients receiving hospital bed fund grants and the actual dollar amounts provided to each patient from such fund; (3) the fair market value of the principal of each individual hospital bed fund, or the principal attributable to each bed fund if held in a pooled investment; (4) the total earnings for each hospital bed fund or the earnings attributable to each hospital bed fund; (5) the dollar amount of earnings reinvested as principal if any; and (6) the dollar amount of earnings available for patient care. The information compiled pursuant to this subsection shall be permanently retained by the hospital and made available to the **[**Office of Health Care Access**]** Health Systems Planning Unit upon request.

Sec. 113. Subsections (e) to (g), inclusive, of section 33-182bb of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(e) Any medical foundation organized on or after July 1, 2009, shall file a copy of its certificate of incorporation and any amendments to its

certificate of incorporation with the [Office of Health Care Access division of the Department of Public Health] Health Systems Planning Unit of the Office of Health Strategy not later than ten business days after the medical foundation files such certificate of incorporation or amendment with the Secretary of the State pursuant to chapter 602.

(f) Any medical group clinic corporation formed under chapter 594 of the general statutes, revision of 1958, revised to 1995, which amends its certificate of incorporation pursuant to subsection (a) of section 33-182cc, shall file with the [Office of Health Care Access division of the Department of Public Health] Health Systems Planning Unit of the Office of Health Strategy a copy of its certificate of incorporation and any amendments to its certificate of incorporation, including any amendment to its certificate of incorporation that complies with the requirements of subsection (a) of section 33-182cc, not later than ten business days after the medical foundation files its certificate of incorporation or any amendments to its certificate of incorporation with the Secretary of the State.

(g) Any medical foundation, regardless of when organized, shall file notice with the [Office of Health Care Access division of the Department of Public Health] Health Systems Planning Unit of the Office of Health Strategy and the Secretary of the State of its liquidation, termination, dissolution or cessation of operations not later than ten business days after a vote by its board of directors or members to take such action. A medical foundation shall, annually, provide the office with (1) a statement of its mission, (2) the name and address of the organizing members, (3) the name and specialty of each physician employed by or acting as an agent of the medical foundation, (4) the location or locations where each such physician practices, (5) a description of the services provided at each such location, (6) a description of any significant change in its services during the preceding year, (7) a copy of the medical foundation's governing documents and bylaws, (8) the name and employer of each member of the board of directors, and (9) other financial information as reported on the medical foundation's most recently filed Internal

Revenue Service return of organization exempt from income tax form, or any replacement form adopted by the Internal Revenue Service, or, if such medical foundation is not required to file such form, information substantially similar to that required by such form. The **[**Office of Health Care Access**]** Health Systems Planning Unit shall make such forms and information available to members of the public and accessible on said **[**office's**]** unit's Internet web site.

Sec. 114. Subsections (b) and (c) of section 19a-493b of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(b) No entity, individual, firm, partnership, corporation, limited liability company or association, other than a hospital, shall individually or jointly establish or operate an outpatient surgical facility in this state without complying with chapter 368z, except as otherwise provided by this section, and obtaining a license within the time specified in this subsection from the Department of Public Health for such facility pursuant to the provisions of this chapter, unless such entity, individual, firm, partnership, corporation, limited liability company or association: (1) Provides to the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy satisfactory evidence that it was in operation on or before July 1, 2003, or (2) obtained, on or before July 1, 2003, from the Office of Health Care Access, a determination that a certificate of need is not required. An entity, individual, firm, partnership, corporation, limited liability company or association otherwise in compliance with this section may operate an outpatient surgical facility without a license through March 30, 2007, and shall have until March 30, 2007, to obtain a license from the Department of Public Health.

(c) Notwithstanding the provisions of this section, no outpatient surgical facility shall be required to comply with section 19a-631, as amended by this act, 19a-632, as amended by this act, 19a-644, as amended by this act, 19a-645, as amended by this act, 19a-646, as

amended by this act, 19a-649, as amended by this act, 19a-664 to 19a-666, inclusive, 19a-673 to 19a-676, inclusive, as amended by this act, 19a-678, 19a-681, as amended by this act, or 19a-683. Each outpatient surgical facility shall continue to be subject to the obligations and requirements applicable to such facility, including, but not limited to, any applicable provision of this chapter and those provisions of chapter 368z not specified in this subsection, except that a request for permission to undertake a transfer or change of ownership or control shall not be required pursuant to subsection (a) of section 19a-638, as amended by this act, if the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy determines that the following conditions are satisfied: (1) Prior to any such transfer or change of ownership or control, the outpatient surgical facility shall be owned and controlled exclusively by persons licensed pursuant to section 20-13 or chapter 375, either directly or through a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13 or chapter 375, or is under the interim control of an estate executor or conservator pending transfer of an ownership interest or control to a person licensed under section 20-13 or chapter 375, and (2) after any such transfer or change of ownership or control, persons licensed pursuant to section 20-13 or chapter 375, a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13 or chapter 375, shall own and control no less than a sixty per cent interest in the outpatient surgical facility.

Sec. 115. Section 19a-6q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) The Commissioner of Public Health, in consultation with the **[**Lieutenant Governor, or the Lieutenant Governor's designee**]**

executive director of the Office of Health Strategy, established under section 19a-754a, as amended by this act, and local and regional health departments, shall, within available resources, develop a plan that is consistent with the Department of Public Health's Healthy Connecticut 2020 health improvement plan and the state healthcare innovation plan developed pursuant to the State Innovation Model Initiative by the Centers for Medicare and Medicaid Services Innovation Center. The commissioner shall develop and implement such plan to: (1) Reduce the incidence of chronic disease, including, but not limited to, chronic cardiovascular disease, cancer, lupus, stroke, chronic lung disease, diabetes, arthritis or another chronic metabolic disease and the effects of behavioral health disorders; (2) improve chronic disease care coordination in the state; and (3) reduce the incidence and effects of chronic disease and improve outcomes for conditions associated with chronic disease in the state.

(b) The commissioner shall, on or before January 15, 2015, and biennially thereafter, submit a report, in consultation with the **[**Lieutenant Governor or the Lieutenant Governor's designee**]** executive director of the Office of Health Strategy, in accordance with the provisions of section 11-4a to the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning chronic disease and implementation of the plan described in subsection (a) of this section. The commissioner shall post each report on the Department of Public Health's Internet web site not later than thirty days after submitting such report. Each report shall include, but need not be limited to: (1) A description of the chronic diseases that are most likely to cause a person's death or disability, the approximate number of persons affected by such chronic diseases and an assessment of the financial effects of each such disease on the state and on hospitals and health care facilities; (2) a description and assessment of programs and actions that have been implemented by the department and health care providers to improve chronic disease care coordination and prevent chronic disease; (3) the sources and amounts of funding received by the department to treat persons with multiple chronic diseases and to treat or reduce the most prevalent

chronic diseases in the state; (4) a description of chronic disease care coordination between the department and health care providers, to prevent and treat chronic disease; and (5) recommendations concerning actions that health care providers and persons with chronic disease may take to reduce the incidence and effects of chronic disease.

Sec. 116. Section 19a-725 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) There is established within the **[**office of the Lieutenant Governor**]** Office of Health Strategy, established under section 19a-754a, as amended by this act, the Health Care Cabinet for the purpose of advising the Governor on the matters set forth in subsection (c) of this section.

(b) (1) The Health Care Cabinet shall consist of the following members who shall be appointed on or before August 1, 2011: (A) Five appointed by the Governor, two of whom may represent the health care industry and shall serve for terms of four years, one of whom shall represent community health centers and shall serve for a term of three years, one of whom shall represent insurance producers and shall serve for a term of three years and one of whom shall be an at-large appointment and shall serve for a term of three years; (B) one appointed by the president pro tempore of the Senate, who shall be an oral health specialist engaged in active practice and shall serve for a term of four years; (C) one appointed by the majority leader of the Senate, who shall represent labor and shall serve for a term of three years; (D) one appointed by the minority leader of the Senate, who shall be an advanced practice registered nurse engaged in active practice and shall serve for a term of two years; (E) one appointed by the speaker of the House of Representatives, who shall be a consumer advocate and shall serve for a term of four years; (F) one appointed by the majority leader of the House of Representatives, who shall be a primary care physician engaged in active practice and shall serve for a term of four years; (G) one appointed by the minority leader of the

House of Representatives, who shall represent the health information technology industry and shall serve for a term of three years; (H) five appointed jointly by the chairpersons of the SustiNet Health Partnership board of directors, one of whom shall represent faith communities, one of whom shall represent small businesses, one of whom shall represent the home health care industry, one of whom shall represent hospitals, and one of whom shall be an at-large appointment, all of whom shall serve for terms of five years; (I) the **[**Lieutenant Governor**]** executive director of the Office of Health Strategy, or the executive director's designee; (J) the Secretary of the Office of Policy and Management, or the secretary's designee; the Comptroller, or the Comptroller's designee; the chief executive officer of the Connecticut Health Insurance Exchange, or said officer's designee; the Commissioners of Social Services and Public Health, or their designees; and the Healthcare Advocate, or the Healthcare Advocate's designee, all of whom shall serve as ex-officio voting members; and (K) the Commissioners of Children and Families, Developmental Services and Mental Health and Addiction Services, and the Insurance Commissioner, or their designees, and the nonprofit liaison to the Governor, or the nonprofit liaison's designee, all of whom shall serve as ex-officio nonvoting members.

(2) Following the expiration of initial cabinet member terms, subsequent cabinet terms shall be for four years, commencing on August first of the year of the appointment. If an appointing authority fails to make an initial appointment to the cabinet or an appointment to fill a cabinet vacancy within ninety days of the date of such vacancy, the appointed cabinet members shall, by majority vote, make such appointment to the cabinet.

(3) Upon the expiration of the initial terms of the five cabinet members appointed by SustiNet Health Partnership board of directors, five successor cabinet members shall be appointed as follows: (A) One appointed by the Governor; (B) one appointed by the president pro tempore of the Senate; (C) one appointed by the speaker of the House of Representatives; and (D) two appointed by majority vote of the

appointed board members. Successor board members appointed pursuant to this subdivision shall be at-large appointments.

(4) The **[**Lieutenant Governor**]** executive director of the Office of Health Strategy, or the executive director's designee, shall serve as the chairperson of the Health Care Cabinet.

(c) The Health Care Cabinet shall advise the Governor regarding the development of an integrated health care system for Connecticut and shall:

(1) Evaluate the means of ensuring an adequate health care workforce in the state;

(2) Jointly evaluate, with the chief executive officer of the Connecticut Health Insurance Exchange, the feasibility of implementing a basic health program option as set forth in Section 1331 of the Affordable Care Act;

(3) Identify short and long-range opportunities, issues and gaps created by the enactment of federal health care reform;

(4) Review the effectiveness of delivery system reforms and other efforts to control health care costs, including, but not limited to, reforms and efforts implemented by state agencies; and

(5) Advise the Governor on matters relating to: (A) The design, implementation, actionable objectives and evaluation of state and federal health care policies, priorities and objectives relating to the state's efforts to improve access to health care, (B) the quality of such care and the affordability and sustainability of the state's health care system, and (C) total state-wide health care spending, including methods to collect, analyze and report health care spending data.

(d) The Health Care Cabinet may convene working groups, which include volunteer health care experts, to make recommendations concerning the development and implementation of service delivery and health care provider payment reforms, including multipayer

initiatives, medical homes, electronic health records and evidenced-based health care quality improvement.

(e) The [office of the Lieutenant Governor and the Office of the Healthcare Advocate] Office of Health Strategy shall provide support staff to the Health Care Cabinet.

Sec. 117. Section 20-195sss of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) As used in this section, "community health worker" means a public health outreach professional with an in-depth understanding of the experience, language, culture and socioeconomic needs of the community who (1) serves as a liaison between individuals within the community and health care and social services providers to facilitate access to such services and health-related resources, improve the quality and cultural competence of the delivery of such services and address social determinants of health with a goal toward reducing racial, ethnic, gender and socioeconomic health disparities, and (2) increases health knowledge and self-sufficiency through a range of services including outreach, engagement, education, coaching, informal counseling, social support, advocacy, care coordination, research related to social determinants of health and basic screenings and assessments of any risks associated with social determinants of health.

(b) The executive director of the [state innovation model initiative program management office] Office of Health Strategy, established under section 19a-754a, as amended by this act, shall, within available resources and in consultation with the Community Health Worker Advisory Committee established by [such] said office and the Commissioner of Public Health, study the feasibility of creating a certification program for community health workers. Such study shall examine the fiscal impact of implementing such a certification program and include recommendations for (1) requirements for certification and renewal of certification of community health workers, including

any training, experience or continuing education requirements, (2) methods for administering a certification program, including a certification application, a standardized assessment of experience, knowledge and skills, and an electronic registry, and (3) requirements for recognizing training program curricula that are sufficient to satisfy the requirements of certification.

(c) Not later than October 1, 2018, the executive director of the **[**state innovation model initiative program management office**]** Office of Health Strategy shall report, in accordance with the provisions of section 11-4a, on the results of such study and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services.

Sec. 118. Section 38a-47 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) All domestic insurance companies and other domestic entities subject to taxation under chapter 207 shall, in accordance with section 38a-48, as amended by this act, annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, an amount equal to: **[**the**]**

(1) The actual expenditures made by the Insurance Department during each fiscal year, and the actual expenditures made by the Office of the Healthcare Advocate, including the cost of fringe benefits for department and office personnel as estimated by the Comptroller; **[**, plus (1) the**]**

(2) The amount appropriated to the Office of Health Strategy from the Insurance Fund for the fiscal year, including the cost of fringe benefits for office personnel as estimated by the Comptroller;

(3) The expenditures made on behalf of the department and **[**the office**]** said offices from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, **[**and (2) the**]** but excluding such

estimated expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy; and

(4) The amount appropriated to the Department of Social Services for the fall prevention program established in section 17a-303a from the Insurance Fund for the fiscal year. **[**, but excluding**]**

(b) The expenditures and amounts specified in subdivisions (1) to (4), inclusive, of subsection (a) of this section shall exclude expenditures paid for by fraternal benefit societies, foreign and alien insurance companies and other foreign and alien entities under sections 38a-49 and 38a-50.

(c) Payments shall be made by assessment of all such domestic insurance companies and other domestic entities calculated and collected in accordance with the provisions of section 38a-48, as amended by this act. Any such domestic insurance company or other domestic entity aggrieved because of any assessment levied under this section may appeal therefrom in accordance with the provisions of section 38a-52.

Sec. 119. Section 38a-48 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) On or before June thirtieth, annually, the Commissioner of Revenue Services shall render to the Insurance Commissioner a statement certifying the amount of taxes or charges imposed on each domestic insurance company or other domestic entity under chapter 207 on business done in this state during the preceding calendar year. The statement for local domestic insurance companies shall set forth the amount of taxes and charges before any tax credits allowed as provided in subsection (a) of section 12-202.

(b) On or before July thirty-first, annually, the Insurance Commissioner and the Office of the Healthcare Advocate shall render to each domestic insurance company or other domestic entity liable for

payment under section 38a-47, as amended by this act: (1) A statement that includes (A) the amount appropriated to the Insurance Department, [and] the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund established under section 38a-52a for the fiscal year beginning July first of the same year, (B) the cost of fringe benefits for department and office personnel for such year, as estimated by the Comptroller, (C) the estimated expenditures on behalf of the department and the [office] offices from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, not including such estimated expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy, and (D) the amount appropriated to the Department of Social Services for the fall prevention program established in section 17a-303a from the Insurance Fund for the fiscal year; (2) a statement of the total taxes imposed on all domestic insurance companies and domestic insurance entities under chapter 207 on business done in this state during the preceding calendar year; and (3) the proposed assessment against that company or entity, calculated in accordance with the provisions of subsection (c) of this section, provided for the purposes of this calculation the amount appropriated to the Insurance Department, [and] the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund plus the cost of fringe benefits for department and office personnel and the estimated expenditures on behalf of the department and the office from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy shall be deemed to be the actual expenditures of the department and the office, and the amount appropriated to the Department of Social Services from the Insurance Fund for the fiscal year for the fall prevention program established in section 17a-303a shall be deemed to be the actual expenditures for the program.

(c) (1) The proposed assessments for each domestic insurance company or other domestic entity shall be calculated by (A) allocating twenty per cent of the amount to be paid under section 38a-47, as

amended by this act, among the domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such entities on business done in this state during the preceding calendar year, and (B) allocating eighty per cent of the amount to be paid under section 38a-47, as amended by this act, among all domestic insurance companies and domestic entities other than those organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such domestic insurance companies and domestic entities on business done in this state during the preceding calendar year, provided if there are no domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the time of assessment, one hundred per cent of the amount to be paid under section 38a-47, as amended by this act, shall be allocated among such domestic insurance companies and domestic entities.

(2) When the amount any such company or entity is assessed pursuant to this section exceeds twenty-five per cent of the actual expenditures of the Insurance Department, **[**and**]** the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund, such excess amount shall not be paid by such company or entity but rather shall be assessed against and paid by all other such companies and entities in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on business done in this state during the preceding calendar year, except that for purposes of any assessment made to fund payments to the Department of Public Health to purchase vaccines, such company or entity shall be responsible for its share of the costs, notwithstanding whether its assessment exceeds twenty-five per cent of the actual expenditures of the Insurance Department, **[**and**]** the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund. The provisions of this subdivision shall not be applicable to any corporation which has converted to a domestic mutual insurance company pursuant to section 38a-155 upon the

effective date of any public act which amends said section to modify or remove any restriction on the business such a company may engage in, for purposes of any assessment due from such company on and after such effective date.

(d) For purposes of calculating the amount of payment under section 38a-47, as amended by this act, as well as the amount of the assessments under this section, the "total taxes imposed on all domestic insurance companies and other domestic entities under chapter 207" shall be based upon the amounts shown as payable to the state for the calendar year on the returns filed with the Commissioner of Revenue Services pursuant to chapter 207; with respect to calculating the amount of payment and assessment for local domestic insurance companies, the amount used shall be the taxes and charges imposed before any tax credits allowed as provided in subsection (a) of section 12-202.

(e) On or before September thirtieth, annually, for each fiscal year ending prior to July 1, 1990, the Insurance Commissioner and the Healthcare Advocate, after receiving any objections to the proposed assessments and making such adjustments as in their opinion may be indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner on or before October thirty-first an amount equal to fifty per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection (g) of this section. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner on or before the following April thirtieth, the remaining fifty per cent of its assessment.

(f) On or before September first, annually, for each fiscal year ending after July 1, 1990, the Insurance Commissioner and the Healthcare Advocate, after receiving any objections to the proposed assessments and making such adjustments as in their opinion may be

indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner (1) on or before June 30, 1990, and on or before June thirtieth annually thereafter, an estimated payment against its assessment for the following year equal to twenty-five per cent of its assessment for the fiscal year ending such June thirtieth, (2) on or before September thirtieth, annually, twenty-five per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection (g) of this section, and (3) on or before the following December thirty-first and March thirty-first, annually, each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner the remaining fifty per cent of its proposed assessment to the department in two equal installments.

(g) If the actual expenditures for the fall prevention program established in section 17a-303a are less than the amount allocated, the Commissioner of Social Services shall notify the Insurance Commissioner and the Healthcare Advocate. Immediately following the close of the fiscal year, the Insurance Commissioner and the Healthcare Advocate shall recalculate the proposed assessment for each domestic insurance company or other domestic entity in accordance with subsection (c) of this section using the actual expenditures made during the fiscal year by the Insurance Department, **[**and**]** the Office of the Healthcare Advocate **[**during that fiscal year**]** and the Office of Health Strategy from the Insurance Fund, the actual expenditures made on behalf of the department and the **[**office**]** offices from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy, and the actual expenditures for the fall prevention program. On or before July thirty-first, the Insurance Commissioner and the Healthcare Advocate shall render to each such domestic insurance company and other domestic entity a statement showing the difference between their respective recalculated assessments and the amount they have

previously paid. On or before August thirty-first, the Insurance Commissioner and the Healthcare Advocate, after receiving any objections to such statements, shall make such adjustments which in their opinion may be indicated, and shall render an adjusted assessment, if any, to the affected companies.

(h) If any assessment is not paid when due, a penalty of twenty-five dollars shall be added thereto, and interest at the rate of six per cent per annum shall be paid thereafter on such assessment and penalty.

(i) The commissioner shall deposit all payments made under this section with the State Treasurer. On and after June 6, 1991, the moneys so deposited shall be credited to the Insurance Fund established under section 38a-52a and shall be accounted for as expenses recovered from insurance companies.

Sec. 120. Subsection (c) of section 1-84b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(c) The provisions of this subsection apply to present or former executive branch public officials or state employees who hold or formerly held positions which involve significant decision-making or supervisory responsibility and are designated as such by the Office of State Ethics in consultation with the agency concerned except that such provisions shall not apply to members or former members of the boards or commissions who serve ex officio, who are required by statute to represent the regulated industry or who are permitted by statute to have a past or present affiliation with the regulated industry. Designation of positions subject to the provisions of this subsection shall be by regulations adopted by the Citizen's Ethics Advisory Board in accordance with chapter 54. As used in this subsection, "agency" means the **[**Office of Health Care Access division within the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy, the Connecticut Siting Council, the Department of Banking, the Insurance Department, the Department of Emergency Services and Public Protection, the office within the

Department of Consumer Protection that carries out the duties and responsibilities of sections 30-2 to 30-68m, inclusive, the Public Utilities Regulatory Authority, including the Office of Consumer Counsel, and the Department of Consumer Protection and the term "employment" means professional services or other services rendered as an employee or as an independent contractor.

(1) No public official or state employee in an executive branch position designated by the Office of State Ethics shall negotiate for, seek or accept employment with any business subject to regulation by his agency.

(2) No former public official or state employee who held such a position in the executive branch shall within one year after leaving an agency, accept employment with a business subject to regulation by that agency.

(3) No business shall employ a present or former public official or state employee in violation of this subsection.

Sec. 121. Section 3-123i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

For the fiscal year ending June 30, 2014, and for each fiscal year thereafter, the Comptroller shall fund the fringe benefit cost differential between the average rate for fringe benefits for employees of private hospitals in the state and the fringe benefit rate for employees of The University of Connecticut Health Center from the resources appropriated for State Comptroller-Fringe Benefits in an amount not to exceed $13,500,000. For purposes of this section, the "fringe benefit cost differential" means the difference between the state fringe benefit rate calculated on The University of Connecticut Health Center payroll and the average member fringe benefit rate of all Connecticut acute care hospitals as contained in the annual reports submitted to the **[**Office of Health Care Access**]** Health Systems Planning Unit of the Office of Health Strategy pursuant to section 19a-644, as amended by this act.

Sec. 122. Subsection (b) of section 4-101a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(b) Grants, technical assistance or consultation services, or any combination thereof, provided under this section may be made to assist a nongovernmental acute care general hospital to develop and implement a plan to achieve financial stability and assure the delivery of appropriate health care services in the service area of such hospital, or to assist a nongovernmental acute care general hospital in determining strategies, goals and plans to ensure its financial viability or stability. Any such hospital seeking such grants, technical assistance or consultation services shall prepare and submit to the Office of Policy and Management and the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy a plan that includes at least the following: (1) A statement of the hospital's current projections of its finances for the current and the next three fiscal years; (2) identification of the major financial issues which effect the financial stability of the hospital; (3) the steps proposed to study or improve the financial status of the hospital and eliminate ongoing operating losses; (4) plans to study or change the mix of services provided by the hospital, which may include transition to an alternative licensure category; and (5) other related elements as determined by the Office of Policy and Management. Such plan shall clearly identify the amount, value or type of the grant, technical assistance or consultation services, or combination thereof, requested. Any grants, technical assistance or consultation services, or any combination thereof, provided under this section shall be determined by the Secretary of the Office of Policy and Management not to jeopardize the federal matching payments under the medical assistance program and the emergency assistance to families program as determined by the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy or the Department of Social Services in consultation with the Office of Policy and Management.

Sec. 123. Subsection (c) of section 17b-337 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(c) The Long-Term Care Planning Committee shall consist of: (1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care; (2) the Commissioner of Social Services, or the commissioner's designee; (3) one member of the Office of Policy and Management appointed by the Secretary of the Office of Policy and Management; (4) **[**two members**]** one member from the Department of Public Health appointed by the Commissioner of Public Health; **[**, one of whom is from the Office of Health Care Access division of the department;**]** (5) one member from the Department of Housing appointed by the Commissioner of Housing; (6) one member from the Department of Developmental Services appointed by the Commissioner of Developmental Services; (7) one member from the Department of Mental Health and Addiction Services appointed by the Commissioner of Mental Health and Addiction Services; (8) one member from the Department of Transportation appointed by the Commissioner of Transportation; **[**and**]** (9) one member from the Department of Children and Families appointed by the Commissioner of Children and Families; and (10) one member from the Health Systems Planning Unit of the Office of Health Strategy appointed by the executive director of the Office of Health Strategy. The committee shall convene no later than ninety days after June 4, 1998. Any vacancy shall be filled by the appointing authority. The chairperson shall be elected from among the members of the committee. The committee shall seek the advice and participation of any person, organization or state or federal agency it deems necessary to carry out the provisions of this section.

Sec. 124. Subsection (g) of section 17b-352 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(g) The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section. **[**The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.**]**

Sec. 125. Subsection (e) of section 17b-353 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(e) The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section. **[**The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.**]**

Sec. 126. Subsection (f) of section 17b-354 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(f) The Commissioner of Social Services may adopt regulations, in accordance with chapter 54, to implement the provisions of this section. **[**The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.**]**

Sec. 127. Section 17b-356 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

Any health care facility or institution, as defined in subsection (a) of section 19a-490, as amended by this act, except a nursing home, rest home, residential care home or residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities, proposing to expand its services by adding nursing home beds shall obtain the approval of the Commissioner of Social Services in accordance with the procedures established pursuant to sections 17b-352, as amended by this act, 17b-353, as amended by this act, and 17b-354, as amended by this act, for a facility, as defined in section 17b-352, as amended by this act, prior to obtaining the approval of the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy pursuant to section 19a-639, as amended by this act.

Sec. 128. Subsection (b) of section 19a-7 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(b) For the purposes of establishing a state health plan as required by subsection (a) of this section and consistent with state and federal law on patient records, the department is entitled to access hospital discharge data, emergency room and ambulatory surgery encounter data, data on home health care agency client encounters and services, data from community health centers on client encounters and services and all data collected or compiled by the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy pursuant to section 19a-613, as amended by this act.

Sec. 129. Subsection (a) of section 19a-507 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) Notwithstanding the provisions of chapter 368z, New Horizons, Inc., a nonprofit, nonsectarian organization, or a subsidiary

organization controlled by New Horizons, Inc., is authorized to construct and operate an independent living facility for severely physically disabled adults, in the town of Farmington, provided such facility shall be constructed in accordance with applicable building codes. The Farmington Housing Authority, or any issuer acting on behalf of said authority, subject to the provisions of this section, may issue tax-exempt revenue bonds on a competitive or negotiated basis for the purpose of providing construction and permanent mortgage financing for the facility in accordance with Section 103 of the Internal Revenue Code. Prior to the issuance of such bonds, plans for the construction of the facility shall be submitted to and approved by the **[**Office of Health Care Access**]** Health Systems Planning Unit of the Office of Health Strategy. The **[**office**]** unit shall approve or disapprove such plans within thirty days of receipt thereof. If the plans are disapproved they may be resubmitted. Failure of the **[**office**]** unit to act on the plans within such thirty-day period shall be deemed approval thereof. The payments to residents of the facility who are eligible for assistance under the state supplement program for room and board and necessary services, shall be determined annually to be effective July first of each year. Such payments shall be determined on a basis of a reasonable payment for necessary services, which basis shall take into account as a factor the costs of providing those services and such other factors as the commissioner deems reasonable, including anticipated fluctuations in the cost of providing services. Such payments shall be calculated in accordance with the manner in which rates are calculated pursuant to subsection (h) of section 17b-340 and the cost-related reimbursement system pursuant to said section except that efficiency incentives shall not be granted. The commissioner may adjust such rates to account for the availability of personal care services for residents under the Medicaid program. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the

property. The cost basis for such payment shall be subject to audit, and a recomputation of the rate shall be made based upon such audit. The facility shall report on a fiscal year ending on the thirtieth day of September on forms provided by the commissioner. The required report shall be received by the commissioner no later than December thirty-first of each year. The Department of Social Services may use its existing utilization review procedures to monitor utilization of the facility. If the facility is aggrieved by any decision of the commissioner, the facility may, within ten days, after written notice thereof from the commissioner, obtain by written request to the commissioner, a hearing on all items of aggrievement. If the facility is aggrieved by the decision of the commissioner after such hearing, the facility may appeal to the Superior Court in accordance with the provisions of section 4-183.

Sec. 130. Subsection (c) of section 12-263q of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(c) Prior to January 1, 2018, and every three years thereafter, the Commissioner of Social Services shall seek approval from the Centers for Medicare and Medicaid Services to exempt financially distressed hospitals from the net revenue tax imposed on outpatient hospital services. Any such hospital for which the Centers for Medicare and Medicaid Services grants an exemption shall be exempt from the net revenue tax imposed on outpatient hospital services under subsection (a) of this section. Any hospital for which the Centers for Medicare and Medicaid Services denies an exemption shall be required to pay the net revenue tax imposed on outpatient hospital services under subsection (a) of this section. For purposes of this subsection, "financially distressed hospital" means a hospital that has experienced over a five-year period an average net loss of more than five per cent of aggregate revenue. A hospital has an average net loss of more than five per cent of aggregate revenue if such a loss is reflected in the five most recent years of financial reporting that have been made available by the **[**Office of Health Care Access**]** Health Systems Planning Unit of the

Office of Health Strategy for such hospital in accordance with section 19a-670, as amended by this act, as of the effective date of the request for approval which effective date shall be July first of the year in which the request is made.

Sec. 131. Subsection (b) of section 13 of public act 17-4 of the June special session is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(b) The commissioner may impose such conditions as the commissioner determines to be necessary in making any advance in accordance with this section, including, but not limited to, financial reporting, schedule of recoupment of advance payments and adjustments to any future payments to such hospital. For purposes of this section, "distressed hospital" means a short-term general acute care hospital licensed by the Department of Public Health that (1) the Commissioner of Social Services determines is financially distressed in accordance with financial criteria selected or developed by the commissioner, and (2) is independent and is not affiliated with any other hospital or hospital-based system that includes two or more hospitals, as documented through the certificate of need process administered by the **[**Department of Public Health, Office of Health Care Access**]** Health Systems Planning Unit of the Office of Health Strategy.

Sec. 132. Subsection (b) of section 10a-109gg of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(b) The proceeds of the sale of the bond issuance described in subsection (a) of this section shall be used by the Office of Policy and Management, in consultation with the chairperson of the Board of Trustees of the university, for the purpose of the UConn health network initiatives in the following manner: (1) Five million dollars of such proceeds shall be used by Hartford Hospital to develop a simulation and conference center on the Hartford Hospital campus to be run exclusively by Hartford Hospital, (2) five million dollars of such

proceeds shall be used to fulfill the initiative for a primary care institute on the Saint Francis Hospital and Medical Center campus, (3) five million dollars of such proceeds shall be used to fulfill the initiatives for a comprehensive cancer center and The University of Connecticut-sponsored health disparities institute; (4) five million dollars of such proceeds shall be used to fulfill the initiatives for the planning, design, land acquisition, development and construction of (A) a cancer treatment center to be constructed by, or in partnership with, The Hospital of Central Connecticut, provided such cancer treatment center is located entirely within the legal boundaries of the city of New Britain, (B) renovations and upgrades to the oncology unit at The Hospital of Central Connecticut, and (C) if certificate of need approval is received, **[**pursuant to the provisions of subsection (b) of section 10a-109ii,**]** a Permanent Regional Phase One Clinical Trials Unit located at The Hospital of Central Connecticut in New Britain; and (5) two million dollars of such proceeds shall be used to fulfill the initiatives for patient room renovations at Bristol Hospital. In the event that the cancer treatment center authorized pursuant to subdivision (4) of this subsection is built in whole or in part outside the legal boundaries of the city of New Britain, The Hospital of Central Connecticut shall repay the entire amount of the proceeds used to fulfill the initiatives for the planning, design, development and construction of such center.

Sec. 133. Subsection (d) of section 1-84 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(d) No public official or state employee or employee of such public official or state employee shall agree to accept, or be a member or employee of a partnership, association, professional corporation or sole proprietorship which partnership, association, professional corporation or sole proprietorship agrees to accept any employment, fee or other thing of value, or portion thereof, for appearing, agreeing to appear, or taking any other action on behalf of another person before the Department of Banking, the Office of the Claims

Commissioner, the [Office of Health Care Access division within the Department of Public Health] Health Systems Planning Unit of the Office of Health Strategy, the Insurance Department, the Department of Consumer Protection, the Department of Motor Vehicles, the State Insurance and Risk Management Board, the Department of Energy and Environmental Protection, the Public Utilities Regulatory Authority, the Connecticut Siting Council or the Connecticut Real Estate Commission; provided this shall not prohibit any such person from making inquiry for information on behalf of another before any of said commissions or commissioners if no fee or reward is given or promised in consequence thereof. For the purpose of this subsection, partnerships, associations, professional corporations or sole proprietorships refer only to such partnerships, associations, professional corporations or sole proprietorships which have been formed to carry on the business or profession directly relating to the employment, appearing, agreeing to appear or taking of action provided for in this subsection. Nothing in this subsection shall prohibit any employment, appearing, agreeing to appear or taking action before any municipal board, commission or council. Nothing in this subsection shall be construed as applying (1) to the actions of any teaching or research professional employee of a public institution of higher education if such actions are not in violation of any other provision of this chapter, (2) to the actions of any other professional employee of a public institution of higher education if such actions are not compensated and are not in violation of any other provision of this chapter, (3) to any member of a board or commission who receives no compensation other than per diem payments or reimbursement for actual or necessary expenses, or both, incurred in the performance of the member's duties, or (4) to any member or director of a quasi-public agency. Notwithstanding the provisions of this subsection to the contrary, a legislator, an officer of the General Assembly or part-time legislative employee may be or become a member or employee of a firm, partnership, association or professional corporation which represents clients for compensation before agencies listed in this subsection, provided the legislator, officer of the General Assembly or

part-time legislative employee shall take no part in any matter involving the agency listed in this subsection and shall not receive compensation from any such matter. Receipt of a previously established salary, not based on the current or anticipated business of the firm, partnership, association or professional corporation involving the agencies listed in this subsection, shall be permitted.

Sec. 134. Section 249 of public act 17-2 of the June special session is repealed. (*Effective from passage*)

Sec. 135. Sections 17a-451b, 17a-560a, 17a-576 and 20-185n of the general statutes are repealed. (*Effective from passage*)

Sec. 136. Sections 10a-109ii, 17b-234, 17b-235, 19a-617b, 19a-637, 19a-755 and 38a-558 of the general statutes are repealed. (*Effective July 1, 2018*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2018*	4-28f
Sec. 2	*October 1, 2018*	19a-55(a)
Sec. 3	*July 1, 2018*	New section
Sec. 4	*from passage*	19a-490(a)
Sec. 5	*from passage*	1-210(b)(18)
Sec. 6	*from passage*	1-210(c)
Sec. 7	*from passage*	5-145a
Sec. 8	*from passage*	5-173
Sec. 9	*from passage*	5-192f(d)
Sec. 10	*from passage*	17a-450(b)
Sec. 11	*from passage*	17a-450(c)(3)
Sec. 12	*from passage*	17a-450a(a)
Sec. 13	*from passage*	17a-458(c)
Sec. 14	*from passage*	17a-470
Sec. 15	*from passage*	17a-471a
Sec. 16	*from passage*	17a-472
Sec. 17	*from passage*	17a-495
Sec. 18	*from passage*	17a-496
Sec. 19	*from passage*	17a-497(b)
Sec. 20	*from passage*	17a-498(g)

Sec. 21	*from passage*	17a-499
Sec. 22	*from passage*	17a-500(a)
Sec. 23	*from passage*	17a-501
Sec. 24	*from passage*	17a-504
Sec. 25	*from passage*	17a-505
Sec. 26	*from passage*	17a-517
Sec. 27	*from passage*	17a-519
Sec. 28	*from passage*	17a-521
Sec. 29	*from passage*	17a-525
Sec. 30	*from passage*	17a-528(a)
Sec. 31	*from passage*	17a-548(a)
Sec. 32	*from passage*	17a-560
Sec. 33	*from passage*	17a-561
Sec. 34	*from passage*	17a-562
Sec. 35	*from passage*	17a-564
Sec. 36	*from passage*	17a-565
Sec. 37	*from passage*	17a-566
Sec. 38	*from passage*	17a-567
Sec. 39	*from passage*	17a-568
Sec. 40	*from passage*	17a-569
Sec. 41	*from passage*	17a-570
Sec. 42	*from passage*	17a-572
Sec. 43	*from passage*	17a-573
Sec. 44	*from passage*	17a-574
Sec. 45	*from passage*	17a-575
Sec. 46	*from passage*	45a-656(d)
Sec. 47	*July 1, 2018*	45a-656(d)
Sec. 48	*from passage*	45a-677(e)
Sec. 49	*from passage*	18-101f
Sec. 50	*from passage*	46a-152(a)
Sec. 51	*from passage*	12-19a(a)
Sec. 52	*from passage*	12-18b(b)(1)(D)
Sec. 53	*October 1, 2018*	New section
Sec. 54	*October 1, 2018*	New section
Sec. 55	*July 1, 2018*	19a-754a
Sec. 56	*July 1, 2018*	4-5
Sec. 57	*July 1, 2019*	4-5
Sec. 58	*July 1, 2018*	19a-755a
Sec. 59	*July 1, 2018*	19a-755b
Sec. 60	*July 1, 2018*	38a-477e(a)
Sec. 61	*July 1, 2018*	17b-59a

Sec. 62	*July 1, 2018*	17b-59c
Sec. 63	*July 1, 2018*	17b-59d(d)(1)
Sec. 64	*July 1, 2018*	17b-59d(f)
Sec. 65	*July 1, 2018*	17b-59f
Sec. 66	*July 1, 2018*	17b-59g
Sec. 67	*July 1, 2018*	2-124a(b)
Sec. 68	*July 1, 2018*	19a-612
Sec. 69	*July 1, 2018*	19a-612d
Sec. 70	*July 1, 2018*	19a-613
Sec. 71	*July 1, 2018*	19a-614
Sec. 72	*July 1, 2018*	19a-630
Sec. 73	*July 1, 2018*	19a-631(b)
Sec. 74	*July 1, 2018*	19a-632
Sec. 75	*July 1, 2018*	19a-632a(b)
Sec. 76	*July 1, 2018*	19a-632a(f)
Sec. 77	*July 1, 2018*	19a-633
Sec. 78	*July 1, 2018*	19a-634
Sec. 79	*July 1, 2018*	19a-638
Sec. 80	*July 1, 2018*	19a-639
Sec. 81	*July 1, 2018*	19a-639a
Sec. 82	*July 1, 2018*	19a-639b
Sec. 83	*July 1, 2018*	19a-639c
Sec. 84	*July 1, 2018*	19a-639e
Sec. 85	*July 1, 2018*	19a-639f
Sec. 86	*July 1, 2018*	19a-641
Sec. 87	*July 1, 2018*	19a-642
Sec. 88	*July 1, 2018*	19a-643
Sec. 89	*July 1, 2018*	19a-644
Sec. 90	*July 1, 2018*	19a-645
Sec. 91	*July 1, 2018*	19a-646
Sec. 92	*July 1, 2018*	19a-649
Sec. 93	*July 1, 2018*	19a-653
Sec. 94	*July 1, 2018*	19a-654
Sec. 95	*July 1, 2018*	19a-659
Sec. 96	*July 1, 2018*	19a-670
Sec. 97	*July 1, 2018*	19a-673(a)(1)
Sec. 98	*July 1, 2018*	19a-673a
Sec. 99	*July 1, 2018*	19a-673c
Sec. 100	*July 1, 2018*	19a-676
Sec. 101	*July 1, 2018*	19a-681
Sec. 102	*July 1, 2018*	19a-486

Sec. 103	*July 1, 2018*	19a-486a
Sec. 104	*July 1, 2018*	19a-486b
Sec. 105	*July 1, 2018*	19a-486d
Sec. 106	*July 1, 2018*	19a-486e
Sec. 107	*July 1, 2018*	19a-486f
Sec. 108	*July 1, 2018*	19a-486g
Sec. 109	*July 1, 2018*	19a-486h
Sec. 110	*July 1, 2018*	19a-486i(d) to (i)
Sec. 111	*July 1, 2018*	19a-508c(j) to (m)
Sec. 112	*July 1, 2018*	19a-509b(c) to (f)
Sec. 113	*July 1, 2018*	33-182bb(e) to (g)
Sec. 114	*July 1, 2018*	19a-493b(b) and (c)
Sec. 115	*July 1, 2018*	19a-6q
Sec. 116	*July 1, 2018*	19a-725
Sec. 117	*July 1, 2018*	20-195sss
Sec. 118	*July 1, 2018*	38a-47
Sec. 119	*July 1, 2018*	38a-48
Sec. 120	*July 1, 2018*	1-84b(c)
Sec. 121	*July 1, 2018*	3-123i
Sec. 122	*July 1, 2018*	4-101a(b)
Sec. 123	*July 1, 2018*	17b-337(c)
Sec. 124	*July 1, 2018*	17b-352(g)
Sec. 125	*July 1, 2018*	17b-353(e)
Sec. 126	*July 1, 2018*	17b-354(f)
Sec. 127	*July 1, 2018*	17b-356
Sec. 128	*July 1, 2018*	19a-7(b)
Sec. 129	*July 1, 2018*	19a-507(a)
Sec. 130	*July 1, 2018*	12-263q(c)
Sec. 131	*July 1, 2018*	PA 17-4 of the June Sp. Sess., Sec. 13(b)
Sec. 132	*July 1, 2018*	10a-109gg(b)
Sec. 133	*July 1, 2018*	1-84(d)
Sec. 134	*from passage*	Repealer section
Sec. 135	*from passage*	Repealer section
Sec. 136	*July 1, 2018*	Repealer section

Statement of Legislative Commissioners:

In Section 17, Subsecs. (a), (c) and (d) were added for purposes of incorporating a conforming change into Subsec. (d). In Section 36(a), in the first sentence, "hospital" was changed to "Whiting Forensic Hospital", for clarity. In Section 53(e), ", or to the person or persons

designated by the commissioner to receive such reports," was added after "Services" for consistency. In Section 54(a), in the first sentence, "commissioner" was changed to "Commissioner of Mental Health and Addiction Services" for clarity; and in Section 54(e)(2) ", neglect, or exploitation" was deleted for consistency.

PH *Joint Favorable Subst.*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 19 $	FY 20 $
Public Health, Dept.	GF - Cost	141,750	141,750
State Comptroller - Fringe Benefits[1]	GF - Cost	17,711	17,711
Mental Health & Addiction Serv., Dept.	GF - Cost	1 million	3.1 million
State Comptroller - Fringe Benefits	GF - Cost	363,300	1.1 million
Resources of the General Fund	GF - Potential Revenue Gain	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill does the following: (1) makes conforming statutory changes to Executive Order No. 63, which designated the Whiting Forensic Division of Connecticut Valley Hospital (CVH) as a separate hospital entity effective 12/31/17, (2) requires any disorder included on the federal Recommended Uniform Screening Panel (RUSP) to be included in Connecticut's Newborn Screening Program, and (3) creates a new category of mandated reporter for abuse of patients at certain Department of Mental Health and Addiction Services (DMHAS)-operated facilities. The fiscal impacts of these three items are discussed below. Other provisions of the bill are not anticipated to have a fiscal impact.

(1) The establishment of Whiting Forensic Hospital results in a state cost of approximately $1.4 million in FY 19. DMHAS must support

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 36.33% of payroll in FY 19 and FY 20.

additional staff at the new hospital, as well as CVH, to ensure that these institutions are separate and distinct entities. Based on an initial evaluation, 30 DMHAS employees (including Behavioral Health Clinical Managers, Advanced Nurse Practitioners, and pharmacy staff) will be needed at an anticipated cost of approximately $1 million in FY 19 and $3.1 million in FY 20 (annualized), with associated fringe benefit costs of $363,300 in FY 19 and $1.1 million in FY 20.

(2) The RUSP provision results in a state cost of approximately $160,000 annually. This includes support for a Department of Public Health (DPH) Health Program Assistant I (approximately $49,000 annually), associated fringe benefits (approximately $18,000 annually), and other expenses for testing (approximately $93,000 annually) to expand the Connecticut Newborn Screening Program to include Pompe Disease and Mucopolysaccharidosis Type I.

(3) A new category of mandated reporter for abuse of patients at certain DMHAS-operated facilities could result in a General Fund revenue gain to the extent fines are imposed on mandated reporters that fail to comply with reporting requirements. A mandated reporter that fails to report abuse to DMHAS within 72-hours can be fined up to $500. If the failure was intentional, the reporter could be fined up to $500 for the first offense and up to $2,000 for any subsequent offense.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, and the extent to which fines are imposed on mandated reporters.

OLR Bill Analysis

sSB 16

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS REGARDING PUBLIC HEALTH.

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§§ 135 & 136 — REPEALERS

Repeals obsolete provisions in various DPH- and DMHAS-related statutes

BACKGROUND

The bill also makes various minor, technical, and conforming changes.

EFFECTIVE DATE: July 1, 2018, unless otherwise noted below.

§ 1 — TOBACCO AND HEALTH TRUST FUND BOARD

Requires the Tobacco and Health Trust Fund Board to report to the legislature only following a fiscal year when it receives a deposit from the Tobacco Settlement Fund, instead of annually; eliminates the requirement that the board meet at least biannually

Current law requires the Tobacco and Health Trust Fund Board to report (1) its activities and accomplishments to the Appropriations and Public Health committees by January 1st annually and (2) all disbursements and expenditures and an evaluation of fund recipients' performance and impact to the legislature by February 1st annually. The bill instead requires the board to submit these reports only following a fiscal year in which the trust fund receives a deposit from the Tobacco Settlement Fund.

The bill also eliminates current law's requirement that the 17-member board meet at least biannually.

EFFECTIVE DATE: October 1, 2018

§ 2 — DPH NEWBORN SCREENING PROGRAM

Expands the Department of Public Health's (DPH) Newborn Screening Program to include screening for any disorder recommended on the U.S. Department of Health and Human Services' uniform newborn screening panel, if the Office of Policy and Management Secretary approves it

By law, the Department of Public Health (DPH) administers a newborn screening program that requires all health care institutions caring for newborn infants to test them for certain genetic and metabolic disorders, including (1) amino and organic acid disorders and (2) fatty acid oxidation disorders. The bill requires newborns to be screened for any other disorder recommended on the federal Department of Health and Human Services' uniform newborn screening panel, if the Office of Policy and Management Secretary approves it.

By law, in addition to the initial screening test, the program directs parents of identified infants to appropriate treatment.

Separate from the newborn screening program, the law also requires these institutions to test infants for such things as (1) critical congenital heart disease, (2) cystic fibrosis, and (3) under certain conditions, cytomegalovirus (CGS § 19a-55).

EFFECTIVE DATE: October 1, 2018

§§ 3 & 134 — REDUCTIONS FOR MUNICIPAL AND DISTRICT HEALTH DEPARTMENTS

Requires DPH to reduce payments to municipal and district health departments proportionally if the total amount of these payments in a fiscal year exceeds the appropriated amount; repeals a related provision in PA 17-2, JSS

The bill repeals a provision in PA 17-2, JSS (§ 249) that requires the DPH commissioner to reduce, on a pro rata basis, payments to municipal and district health departments by a total of $504,218 for FY 19. It instead requires DPH to reduce payments to municipal and district health departments proportionately if the total amount of these payments in a fiscal year exceeds the appropriated amount.

To receive state funding, existing law requires that, among other things, (1) municipalities have a full-time health department and a

population of at least 50,000 and (2) health districts have a total population of at least 50,000 or serve three or more municipalities, regardless of their combined total population.

EFFECTIVE DATE: July 1, 2018, except that the provision repealing PA 17-2, JSS (§ 249) takes effect upon passage.

§§ 4-52 & 135 — WHITING FORENSIC HOSPITAL

Subjects Whiting Forensic Hospital to DPH licensure and regulation, which it is currently exempt from; makes various minor, technical, and conforming changes to reflect the hospital's separation from Connecticut Valley Hospital pursuant to 2017 Executive Order 63

In December 2017, the governor issued Executive Order 63, which designated Whiting Forensic Hospital as an independent division within the Department of Mental Health and Addiction Services (DMHAS), instead of a division of Connecticut Valley Hospital (CVH). The bill effectuates the executive order by making various minor, technical, and conforming changes to reflect the hospital's separation from CVH.

As under current law, Whiting Forensic Hospital remains under DMHAS administrative control and supervision. But the bill subjects it to DPH regulation by adding Whiting Forensic Hospital to the statutory definition of health care "institution." In doing so, the bill subjects Whiting Forensic Hospital to DPH hospital licensure, inspection, and complaint investigation requirements. Under current law, state psychiatric hospitals are not licensed and are exempt from DPH regulation.

By law, Whiting Forensic Hospital, under maximum security conditions, generally provides care for patients with psychiatric issues, some of whom have been convicted of serious offenses or were found incompetent to stand trial.

EFFECTIVE DATE: Upon passage, except for a technical change (§ 47) which takes effect July 1, 2018.

DMHAS Control (§ 16)

The bill requires the director of Whiting Forensic Hospital to report to the DMHAS commissioner, instead of CVH's director of forensic services.

Searches of Patients' Personal Belongings (§ 31)

Current law prohibits Whiting Forensic Hospital patients from being present when their personal belongings are searched. The bill specifies that this prohibition applies only to patients in the hospital's maximum security service, and not those in other units.

Advisory Board (§ 36)

The bill requires the Whiting Forensic Hospital's nine-member advisory board to develop policies and set standards related to hospital patients. The policies and standards must ensure that no discharge of a patient admitted to the hospital under Superior Court commitment or client transfer from the Department of Correction occurs without complying with applicable state laws.

§ 53 — MANDATORY REPORTING OF SUSPECTED PATIENT ABUSE

Establishes mandatory reporting of suspected patient abuse at DMHAS-operated behavioral health facilities by employees who provide direct patient care and licensed health care providers who are facility employees, contractors, or consultants; establishes related reporting requirements and penalties

The bill requires a person to report suspected abuse of a patient receiving services from a DMHAS-operated facility for mental health or substance abuse disorders (i.e., "behavioral health facility") if the person is a mandated reporter who, in the ordinary course of his or her employment, reasonably suspects a patient has:

1. been abused or is in a condition resulting from abuse or
2. had an injury that is at variance with the history given of the injury.

Under the bill, "abuse" means (1) the willful infliction of physical pain, injury, or mental anguish, or (2) a caregiver's willful deprivation of services necessary to maintain a patient's physical and mental

health.

The report must be made to the DMHAS commissioner, or her designee, within 72 hours after the suspicion or belief arose. Under the bill, a mandatory reporter is a behavioral health facility (1) employee paid to provide direct patient care or (2) employee, contractor, or consultant who is a licensed health care provider.

The bill requires behavioral health facilities providing direct patient care to (1) provide mandatory training to mandated reporters on detecting potential patient abuse and (2) inform them of their obligations to report abuse.

Additionally, the bill requires any other person having reasonable cause to suspect such patient abuse to report it to DMHAS in the same manner as the mandated reporters. The DMHAS commissioner, or her designee, must then inform the patient or the patient's legal representative of the services provided by Disability Rights Connecticut, Inc., the state's protection and advocacy system.

EFFECTIVE DATE: October 1, 2018

Report Contents

The bill requires a patient abuse report to include (1) the facility's name and address, (2) the patient's name, (3) information on the nature and extent of the abuse, and (4) any other information the mandatory reporter believes may help the investigation of the case or the patient's protection.

Report Confidentiality

Under the bill, a patient abuse report filed with DMHAS is not disclosable under the Freedom of Information Act. The DMHAS commissioner may disclose information derived from the report for which reasonable grounds are determined to exist after investigation, including the (1) facility's identity, (2) number of complaints received, and (3) number and types of substantiated complaints. But the bill prohibits her from disclosing the patient's name, unless the patient

requests it or a judicial proceeding results from the report.

The bill requires the commissioner, or her designee, to notify the patient's legal representative, if any, within 24 hours, or as soon as possible, after receiving a report of suspected abuse. The commissioner must obtain the legal representative's contact information from the facility.

Under the bill, notification is not required if the legal representative is suspected of causing the abuse that is the subject of the report.

Immunity from Liability

Under the bill, a person who reports suspected patient abuse to DMHAS or who testifies in any related administrative or judicial proceeding is generally immune from civil or criminal liability. The bill exempts from this protection perjury related to making the report, giving false testimony, or making fraudulent or malicious reports (see below).

Penalties

A mandated reporter who fails to report the abuse to DMHAS within the 72-hour deadline can be fined up to $500. If the failure was intentional, the reporter can be charged with a class C misdemeanor (up to three months imprisonment, a fine of up to $500, or both) for the first offense and a class A misdemeanor (up to one year imprisonment, a fine of up to $2,000, or both) for any subsequent offense.

Additionally, a person is guilty of (1) making a fraudulent or malicious patient abuse report or (2) providing false testimony related to such a report, if he or she:

1. willfully makes a fraudulent or malicious report,
2. conspires with another person to make a fraudulent or malicious report or cause such a report to be made, or
3. willfully provides false testimony in any administrative or judicial proceeding related to the patient abuse report.

Violators are guilty of a class A misdemeanor and subject to up to one year imprisonment, a fine of up to $2,000, or both.

Whistleblower Protection

Under the bill, a person who is discharged, or who is discriminated or retaliated against for making a patient abuse report in good faith is entitled to all remedies available by law.

§ 54 — PATIENT ABUSE INVESTIGATIONS

Requires the DMHAS commissioner to investigate reports of suspected abuse of behavioral health facility patients and establishes related requirements, such as disclosure of and access to patient abuse reports and investigations

The bill requires the DMHAS commissioner to investigate reports of suspected abuse of behavioral health facility patients she receives to determine the patient's condition and if any actions or services are required. The investigation must include:

1. an in-person visit with the patient;
2. consultation with individuals having knowledge of the facts surrounding the report; and
3. a patient interview, unless the patient refuses to participate.

After completing the investigation, the bill requires the commissioner to prepare written findings and recommended actions.

EFFECTIVE DATE: October 1, 2018

Investigation Results

The bill requires the commissioner, within 45 days after completing an investigation, to disclose its results in general terms to the person who reported the suspected abuse if the:

1. person who made the report is a mandated reporter (see § 53);
2. information is not otherwise privileged or confidential under state or federal law;

3. names of the witnesses or other people interviewed are kept confidential; and

4. names of the people suspected to be responsible for the abuse are not disclosed, unless they were arrested as a result of the investigation.

Disclosure of Records

Under the bill, DMHAS must maintain a statewide registry of the number of patient abuse reports it receives, the allegations in the reports, and the outcomes of the resulting investigations.

The patient's file, including the original abuse report and investigation report, is not disclosable under the Freedom of Information Act. The bill permits the DMHAS commissioner to disclose part or all of it to a person, agency, corporation, or organization if the patient or patient's legal representative consents to its disclosure or the disclosure is authorized under the bill. But it prohibits the commissioner from disclosing the name of the person who reported the suspected abuse, unless he or she provides written permission or a court order requires the name to be disclosed to a law enforcement officer.

Access to Records

The bill generally permits the patient, or the patient's legal representative or attorney, to access DMHAS records that pertain to or contain information or material concerning the patient. Such records include those concerning investigations; reports; or the patient's medical, psychological, or psychiatric examinations, except:

1. if it includes protected health information from someone other than a health care provider under the promise of confidentiality and the requested access would, with reasonable likelihood, reveal the information's source;

2. information identifying the person who reported the abuse, neglect, or exploitation cannot be released unless the patient

applies to the Superior Court, serves the DMHAS commissioner, and a judge determines, after a private records review and a hearing, there is reasonable cause to believe the person knowingly made a false report or that other interests of justice require the release;

3. if a licensed health care provider determines that the access is reasonably likely to endanger the life or physical safety of the patient or another person;

4. if the protected health information references another person, other than a health care provider, and the requested access would reveal the other person's protected health information; or

5. the access is requested by the patient's legal representative and a licensed health care provider determines in his or her professional judgment, that the requested access is reasonably likely to harm the patient or another person.

§§ 55-136 — OFFICE OF HEALTH STRATEGY

Effectuates the establishment of the Office of Health Strategy (OHS) pursuant to PA 17-2, JSS by making various minor, technical, and conforming changes; transfers administration of the Office of Health Care Access from DPH to OHS and renames the office the Health Systems Planning Unit

PA 17-2, JSS established the Office of Health Strategy (OHS), headed by an executive director appointed by the governor with confirmation by the House or Senate. It placed the office in DPH for administrative purposes only and made it the successor to the:

1. Connecticut Health Insurance Exchange for administering the all-payer claims database and

2. lieutenant governor's office for (a) consulting with DPH to develop a statewide chronic disease plan; (b) housing, chairing, and staffing the Health Care Cabinet; and (c) appointing the state's health information technology officer and overseeing the officer's duties.

The bill also transfers, from DPH to OHS, administration of the Office of Health Care Access and renames the office the Health Systems Planning Unit. Among other things, the office administers the state's certificate of need (CON) program for health care institutions. Under the CON law, health care facilities must generally receive state approval when (1) establishing new facilities or services, (2) changing ownership, (3) acquiring certain equipment, or (4) terminating certain services.

Additionally, the bill transfers, from the State Innovation Model Initiative Program Management Office to the OHS executive director, responsibility for studying the feasibility of creating a certification program for community health workers. As under current law, she must report the study results and recommendations to the Public Health and Human Services committees by October 1, 2018.

Finally, the bill effectuates OHS's establishment by making technical and conforming changes to various statutes.

Responsibilities

The bill adds to OHS's responsibilities, promoting effective health planning and providing health care in Connecticut in a manner that (1) ensures all residents' access to cost-effective health care services, (2) avoids duplicating these services, and (3) improves the availability and financial stability of these services.

Existing law requires the office to perform various responsibilities, such as coordinating the state's health information technology initiatives, developing and implementing a coordinated and cohesive health care vision for the state, and overseeing and directing the Office of Health Care Access, which the bill renames (see above).

Statewide Health Information Technology Plan (§§ 61 & 62)

The bill requires the OHS executive director, instead of the Health Information Technology Officer, to annually report to the Human Services and Public Health committees on (1) the statewide health information technology plan and related uniform data standards used

by specified human services agencies; (2) the statewide health insurance exchange; and (3) legislative, policy, and regulatory recommendations to promote the state's health information technology and exchange goals.

The bill also eliminates a similar requirement that the DSS commissioner annually report the statewide health information technology plan to the Appropriations, Human Services, and Public Health committees.

State Health Information Technology Advisory Council Membership (§ 65)

The bill modifies the membership of the State Health Information Technology Advisory Council by:

1. removing the director of the State Innovation Model Initiative Program Management Office, or the director's designee;

2. adding one member appointed by the OHS executive director, who must be an expert in state health care reform initiatives; and

3. replacing one Connecticut State Medical Society member with a licensed physician appointed by the Senate president pro tempore.

By law, the council advises the state's health information technology officer and, under the bill the OHS executive director, on the statewide health information technology plan and standards for the state's health information exchange, among other things.

Office of Health Care Access (§§ 68-114 & 120-133)

The bill transfers, from DPH to OHS, administration of the Office of Health Care Access (OHCA) and renames the office the Health Systems Planning Unit (HSPU). Among other things, the HSPU administers the state's certificate of need (CON) program for health care institutions. Under the bill, any OHCA order, decision, agreed settlement, or regulation in force on July 1, 2018 is effective until it is amended, repealed, or superseded by law.

Additionally, the bill grants the DPH deputy commissioner independent decision making authority over pending CON applications completed before July 1, 2018. Any further action required after the DPH deputy commissioner issues final decisions on these applications will be decided by the OHS executive director.

The bill imposes a new deadline, October 1, 2018 instead of October 1, 2011, for HSPU to enter into a memorandum of understanding with the comptroller to allow him access to specified collected data from hospitals and outpatient surgical facilities. Such data includes, among other things, patient-identifiable inpatient discharge data, emergency department data, and outpatient provider and patient data. Existing law, unchanged by the bill, requires the comptroller to agree in writing to keep confidential individual patient and provider data, identified by name or personal identification code (§ 94).

Community Health Workers (§ 117)

The bill transfers, from the State Innovation Model Initiative Program Management Office to the OHS executive director, responsibility for studying the feasibility of creating a certification program for community health workers. As under current law, the OHS executive director must do this within available appropriations, and in consultation with the Community Health Worker Advisory Committee.

The OHS executive director must report the study findings and recommendations to the Public Health and Human Services committees by October 1, 2018.

Insurance Assessment to Fund OHS (§§ 118 & 119)

The bill requires Connecticut insurance companies and hospital and medical service corporations to annually pay the insurance commissioner an amount that covers OHS's appropriation, including fringe benefits and capital equipment purchases, except for those made on behalf of HSPU.

Existing law already requires insurance companies and hospital and

medical service corporations to annually pay the insurance commissioner the (1) actual expenditures, including fringe benefits and capital equipment purchases, of the Insurance Department and Office of the Healthcare Advocate and (2) an amount that covers the Department of Social Services' fall prevention program appropriation. As under current law, the bill requires the insurance commissioner to deposit these payments in the Insurance Fund.

The bill makes related technical and conforming changes to the statutory requirements for determining and notifying insurers of their annual assessment amounts.

§§ 135 & 136 — REPEALERS

Repeals obsolete provisions in various DPH- and DMHAS-related statutes

The bill repeals obsolete provisions:

1. requiring DMHAS to complete a program at CVH to consolidate inpatient mental and substance abuse services (CGS § 17a-451b);

2. substituting "Whiting Forensic Institute" for "Whiting Forensic Division" in various statutes (CGS § 17a-560a);

3. establishing an effective date for statutes on evaluating and treating certain individuals with psychiatric disabilities who commit crimes (CGS § 17a-576);

4. establishing a behavior analyst licensing fee expense account within the General Fund to contain behavior analyst license fees to cover necessary DPH staff and equipment costs to collect the fees (DPH now funds the licensure program through its General Fund appropriation and no longer needs a dedicated account) (CGS § 20-185n);

5. transferring, from John Dempsey Hospital to the Connecticut Children's Medical Center, licensure and control of certain neonatal intensive care unit beds after receiving a certificate of need from DPH (CGS § 10a-109ii);

6. (a) requiring DSS to notify the Newington Children's Hospital of each referral for whom it can apply for federal matching grants and (b) permitting the state to pay the hospital retroactive claims related to federal reimbursement claims (CGS §§ 17b-234 & 17b-235);

7. authorizing a demonstration project for long-term acute care hospitals or satellite facilities (CGS § 19a-617b);

8. requiring OHCA to promote effective health planning in the state (CGS § 19a-637);

9. requiring the Lieutenant Governor to designate an individual to serve as Health Information Technology Officer (the bill transfers this responsibility to OHS)(CGS § 19a-755); and

10. requiring OHCA to adopt certain regulations by April 1, 1977 (CGS § 38a-558).

EFFECTIVE DATE: July 1, 2018, except that the first four repealed provisions listed above take effect upon passage.

BACKGROUND

Related Bills

sSB 404, favorably reported by the Public Health Committee, also requires mandatory reporting of suspected patient abuse at DMHAS-operated facilities by specified employees and health care providers.

sSB 406, favorably reported by the Public Health Committee, also subjects Whiting Forensic Hospital to DPH licensure and regulation and makes similar statutory changes to effectuate the hospital's separation from CVH.

sHB 5290, favorably reported by the Public Health Committee, makes similar minor, technical, and conforming changes to effectuate the establishment of OHS.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 24 Nay 3 (03/23/2018)